Namibia HIV Prevention, Care and Support

Program Progress Report:
Quarter 4 (JULY – SEPTEMBER 2010)
ANNUAL (OCTOBER 2009 – SEPTEMBER 2010)

Associate Cooperative Agreement No. 674-A-00-09-00003-00
Reference: Leader Cooperative Agreement No. GPO-A-00-04-00026-00

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List of Acronyms

AB	Abstinence and/or Being Faithful
ACTS	Assess Counsel Test and Support
AIDS	Acquired Immunodeficiency Syndrome
AMS	Anglican Medical Services
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behavior Change Communication
BEN	Bicycle Empowerment Network
BMI	Brief Motivational Intervention
C&T	Care and Treatment
CAA	Catholic Aids Action
CBD	Central Business District
CBO	Community-Based Organization
CCN	Council of Churches in Namibia
CDC	Centers for Disease Control and Prevention
CHS	Catholic Health Services
CM	Community Mobilizers
CT	Counseling and Testing (for HIV)
CTP	Cotrimoxazole Prophylaxis
DAPP	Development AID from People to People
ELCAP	Evangelical Lutheran Church AIDS Program
ELISA	Enzyme-Linked Immunosorbent Assay
EMIS	Education Management Information System
ePMS	Electronic Patient Management System (FileMaker Data System)
EQA	External Quality Assurance
FBO	Faith-Based Organization
FP	Family Planning
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HRMIS	Human Resource Management Information Systems (MoHSS Sub Division)
HRIMS	Human Resource Information Management System (Office of the Prime Minister)
HRIS	Human Resources Information System
HVCT	HIV Counseling and Testing

IMAI	Integrated Management of Adolescent and Adult Illness
IPT	INH Preventive Therapy
IT	Information Technology
LL/CL	LifeLine/ChildLine
LMS	Lutheran Medical Services
MCP	Multiple Concurrent Partnership
M&E	Monitoring and Evaluation
MIS	Management Information System
MoHSS	Ministry of Health and Social Services
MOU	Memorandum of Understanding
NDF	National Defence Forces
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NRCS	Namibia Red Cross Society
NS	New Start
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLHIV	Person Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PO	HIV Prevention Officer
PwP	Prevention with Positives
RMT	Regional Management Team
RT	Rapid Testing
RTK	Rapid Test Kit
SCMS	Supply Chain Management Systems
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing (for HIV)

1. Program Results (required)

See Excel spreadsheet ("INTRAHEALTH FY10 Q4 Oct2010") and complete worksheet ("1. Program results.Q4") on table of program results.

2. PROGRAM-AREA NARRATIVES FOR JULY – SEPTEMBER 2010

Throughout Year 2 of the Agreement and the fourth quarter of FY2010, IntraHealth and its partners, Anglican Medical Services, Catholic AIDS Action, Catholic Health Services, Democratic Resettlement Committee, Development Aid from People to People, Evangelical Lutheran Church AIDS Programme, Lifeline/Childline, Lutheran Medical Services, Namibian Red Cross Society, and Walvis Bay Multi-Purpose Centre, engaged in a variety of key activities to continue combating the HIV epidemic in Namibia. During the fourth quarter, IntraHealth provided technical and training support to all its partners in the different program areas.

Most keys targets for FY2010 were achieved and in some cases exceeded particularly for PMTCT, VCT, Care and Treatment. The substantial HCT budget cuts will result in the cessation of funding to 7 standalone New Start centers starting in COP10. In response to these budget changes, IntraHealth has made some structural changes with regards to staffing levels to reflect the scaling down of standalone VCT activities and scale up of other activities such as male circumcision (MC). The HRIS program scored successes resulting in the handover of computer equipments and the completion of the HRIMS to all the 13 regions in Namibia. The Prevention activities were strengthened in the hospital facilities.

2.1 Program Area 1: *Prevention of Mother-to-Child Transmission of HIV (PMTCT)*

Under Intermediate Result (IR) 2, the prevention of mother-to-child transmission (PMTCT) program is aimed at reducing the HIV incidence related to vertical transmission by increasing the proportion of HIV-positive women and their exposed babies provided with antiretroviral (ARV) prophylaxis. Ensuring availability of ARV drugs to mothers and their newborns, safe childbirth, infant feeding counseling, family planning (FP) counseling and referral, and continuity of care are the key components of the IntraHealth-supported PMTCT program. These interventions are accessed through antenatal clinics and labor and delivery wards in six mission facilities (five faith-based hospitals and one health center).

By the end of the reporting period, 54 outlets in and around mission facilities were supported in providing PMTCT services. These sites include the 5 IntraHealth supported district hospitals, 1 health centre, and the surrounding facilities which fall under our partners, though are not necessarily faith-based facilities. At present, only 7 facilities within the catchment areas of the Mission district hospitals are not yet providing PMTCT services.

Accomplishments & Successes

Antenatal Care: During the fourth quarter, a total of 2,589 women attended a first ANC visit, of which 221(8.5%) started ANC with known HIV positive status, and 2,368(91.5%) with unknown status. Of those mothers with unknown HIV status, 2,103(89%) were newly tested in the fourth quarter and received their HIV test results. The total number of pregnant women with known HIV status is 2,324 in ANC.

The data for the entire FY2010 reporting period also demonstrates IntraHealth's accomplishments in this area. A total of 10,496 women attended a first ANC visit, of which 895 (8.5%) started ANC with known HIV positive status, and 9.601 (91.5%) with unknown status. Of those mothers with unknown HIV status, 8.475 (88%) were newly tested in the fourth quarter and received their HIV test results. The total number of pregnant women with known HIV status is 9.370 for the entire FY2010 in ANC.

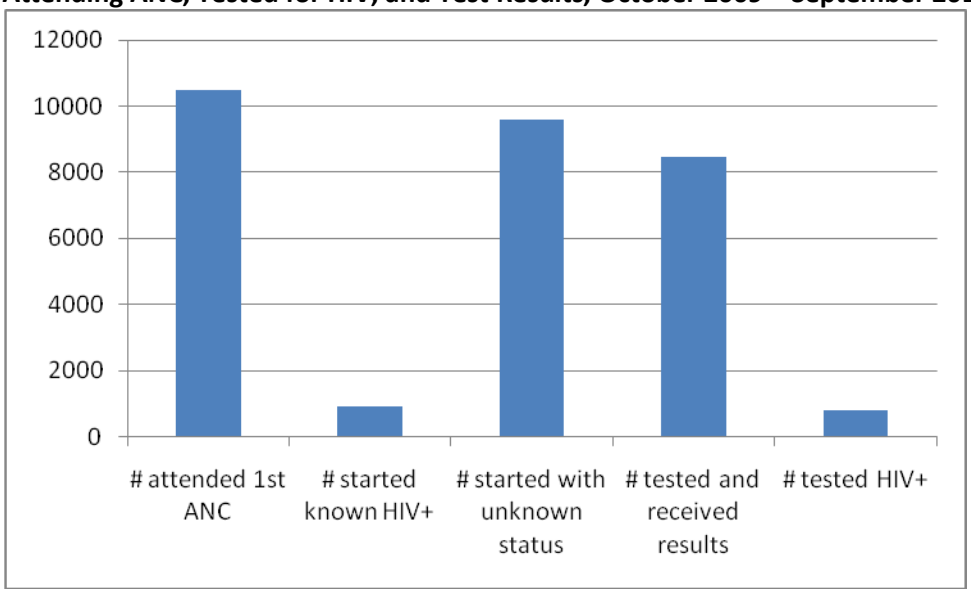
The FY2010 target of 6,500 pregnant women who knew their status (in both ANC and labor), comprised of those known to be HIV+ at entry, those tested through the ANC entry point and those tested in labor and delivery, has been exceeded by 40%.

For the pregnant women counseled and tested in the fourth quarter, 191 (9%) tested HIV+. These numbers include women attending ANC at peripheral clinics within mission-supported districts that are receiving indirect support from IntraHealth. For FY2010, the totals for pregnant women counseled and tested HIV+ were 791 (9%) (see *Figure 1* below).

As part of the couple counseling program within PMTCT, among the 2,368 women counseled and tested, 84 (3.5 %) were tested along with their partners during the fourth quarter. Of the 84 men tested during the fourth quarter, 15 (18%) tested HIV+. In addition, 25 male partners had a known HIV+ status. All the women testing HIV positive were referred for enrollment into HIV care and assessment for treatment. Those women testing HIV negative before the third trimester were counseled to stay negative, and a repeat test is encouraged during the last trimester.

The results for FY2010 in the couple counseling program show that during the entire year 9,601 women were counseled and tested, with 480 (5 %) tested along with their partners. Of the 480 men tested during the year, 96 (20%) tested HIV+. In addition, an annual total of 66 male partners had a known HIV+ status.

Figure 1: Women Attending ANC, Tested for HIV, and Test Results, October 2009 – September 2010



Labor & Delivery: For the 2,811 women who delivered in IntraHealth supported health facilities during the fourth quarter of FY2010, 2,727(97%) knew their HIV status. During the same period, a total of 464 HIV+ women delivered in these facilities, of which 151 (33%) received ART and 249 (54%) received ARV prophylaxis. A total of 457 babies received ARV prophylaxis during the fourth quarter. Most (80%) HIV+ women chose exclusive breastfeeding as their preferred infant feeding option.

For the year, 9,920 women delivered in IntraHealth supported health facilities with 9,532 (96%) aware of their HIV status. 1,688 HIV+ women delivered in the same facilities, of which a yearly total of 389 (23%) received ART and 1,224 (73%) received ARV prophylaxis. For all of FY2010 1,682 babies received ARV prophylaxis and most (92%) HIV+ women chose exclusive breastfeeding as their preferred infant feeding option.

Postnatal Care: A total of 485 exposed babies were tested with DNA polymerase chain reaction (PCR) during the fourth quarter, of which 43 (8.9%) tested HIV+. Overall, during FY2010, 1,238 exposed infants were tested, of which 81 (6.5%) tested HIV+.

HIV & FP Integration: Of the 300 positive women enrolled in to postnatal care during the reporting period, 295 (98%) were referred for family planning (FP) services. Of the 295 referred women, 234 (79%) reached and enrolled in family planning. For the year, 769 positive women were referred for FP services with 620 (81%) having reached and enrolled in FP.

Additional Highlights

- IntraHealth conducted an assessment of emergency obstetric care (EMOC) services in the 6 hospitals/health center that it supports to identify priority areas in preparation for the EMOC program to start in COP10. The priority areas identified were in line with the MoHSS roadmap to reducing maternal and newborn morbidity and mortality. A draft program description was subsequently developed and has been shared with USAID.
- IntraHealth conducted quarterly support and supervision to all the 6 FBHs during the fourth quarter

- Participated in the joint support and supervisory visits with the MoHSS in the fourth quarter

Challenges, Constraints & Plans to Overcome Them

- The average dropout rate of HIV exposed infants from follow up is estimated to be about 25-30%. This percentage could be an over estimate as some of these infants may actually be followed up in adjacent districts or may still come to the health facility and not be picked up or recorded. Nevertheless, tracking these children is vital to ensuring they receive appropriate care and follow up. IntraHealth will continue working with MoHSS in order to establish an adequate system of following up babies. One opportunity to integrate the follow up of HIV exposed infants is through the immunization program, which will be explored further.

Planned Events for the Next Quarter

- Quarterly support visits
- Revision of supervision tool to incorporate the PI approach

2.2 Program Area 2: *Male Circumcision*

Under IR2, IntraHealth works to improve access to high quality HIV prevention services. IntraHealth strives to make men aware of, and have access to, quality medical male circumcision (MC) services as part of the HIV prevention strategies. Activities are aimed at ensuring a minimum MC package is provided, including screening and management of sexually transmitted infections, behavioral change counseling (risk reduction), and provider initiated testing and counseling and condom promotion and distribution. Currently, two IntraHealth supported sites (Onandjokwe, Nyangana), are providing MC according to WHO standards.

IntraHealth is an active member of the Namibian MC task force, and will continue to contribute to the development and implementation of a national MC strategy and supporting policies and technical recommendations. In addition, IntraHealth is actively involved in advocacy and communication efforts to ensure safe male circumcision is available throughout the country.

Accomplishments & Successes

- During the fourth quarter of FY2010, 30 (6 from Nyangana hospital and 24 from Onandjokwe hospital) men were circumcised as part of minimum package of MC for prevention services , making a total of 102 males total during the four quarters of FY2010 (*Note:* the other pilot sites will be report results via CDC). During the fourth quarter, no adverse events reported and all clients returned on day 2 and day 7 for the necessary follow-up.

- One Medical Officer, one nurse and two counselors from Nyanagana hospital were trained according to WHO/JHPIEGO standards, making it two IntraHealth supported sites trained.

- IntraHealth is also active in facilitating training in collaboration with I-Tech and the MoHSS. Furthermore, IntraHealth staff performs MC at Windhoek Central Hospital at least twice a month.

- One IntraHealth staff (Prevention Supervisor) and two Technical advisors (VCT and M&E) were trained in MC for implementers (2 week training) and for Managers (three day training) respectively.

- IntraHealth contributed to the finalized MC policy and supported the MC task force with planned activities such as training, S&T payment for trained health workers and managers. A total of 123 health workers

including 29 doctors, 39 nurses, 56 community counselors, and 46 managers across the country were trained.

- MC messages are integrated in the prevention strategy. All community mobilizers and prevention officers incorporate MC messages in to their talks.

- A team composed of I-Tech, IntraHealth, JPHIEGO and the MOHSS conducted a support visit to all pilot sites to ensure that MC is being practiced according to standards. Onandjokwe, Oshakati and Windhoek Central Hospital were visited. In terms of the procedure, all providers observed complied with currently accepted standards.

- The development of the MC strategy is in process. The consultant solicitation process is underway and interviews will be conducted in the next quarter from a short list of highly skilled candidates in order to select a suitable individual to fulfill the scope of work.

Challenges, Constraints and Plans to Overcome Them

- In spite of significant adjustments at Onandjokwe and MC information dissemination, the number of procedures had remained low. Shortage of staff and low MC demand are the main reasons for low uptake. IntraHealth will support Onandjokwe in strengthening demand creation in collaboration with the community mobilizers and prevention officers.
- Of the 4 trained doctors in MC in Onandjokwe, two left the organization and one is very busy with the mainstream hospital activities. The only available MC doctor is the Programme Manager also committed to many other activities pertaining the running of the centre.
- Nyangana experienced a critical shortage of staff due to resignation of two doctors leaving the institution with only two medical officers including the Principal Medical Officer. This situation led to poor MC roll out in the district. Currently two other doctors are employed and hope that the MC uptake will increase in the next quarter.
- Since the policy was not finalized in the last quarter, the demand creation through media was not conducted. IntraHealth will ensure that demand creation through media is conducted in the next quarter, since the policy has been finalized.
- Only one IntraHealth supported site was trained in the last quarter. Intrahealth will collaborate with the MOHSS and I-Tech in order to train all IntraHealth supported sites in the coming year.

Planned Events for the Next Quarter

- Continue strengthening and emphasizing the importance of MC during VCT and encourage community mobilization around MC.
- Create demand through media in order to increase MC uptake.
- Training the four IntraHealth supported sites on MC in the next COP.
- Continue Training of Managers from IntraHealth supported sites.
- Continue attending MC task force meetings.
- Continue to perform MC at Windhoek Central Hospital at demand, since there is now a dedicated team for MC at WCH.
- Oversee the development of a costed implementation plan for MC in Namibia
- Organize campaign in IntraHealth supported sites in the next COP
- Provide MC kits in all IntraHealth supported sites in the next quarter

2.3 Program Area 3: *Post Exposure Prophylaxis (PEP)*

Under IR2, IntraHealth aims to improve access to quality HIV prevention services. According to the national guidelines which contain protocols for effective implementation of post exposure prophylaxis (PEP), it is to be provided within 72 hours following occupational or sexual exposure. IntraHealth will work towards strengthening implementation of PEP guidelines and will focus on data collection and reporting systems, while supporting training and skill updates, in order to improve awareness and close the gaps on missed opportunities for PEP within Namibian health facilities.

Accomplishments & Successes

All staff members working at IntraHealth supported sites have been oriented in PEP. During the fourth quarter of FY2010, a total of 23 individuals received PEP at these sites, with 9 post occupational exposure, 12 victims of rape and 2 other non occupational exposures including condom failures . All recipients of PEP tested HIV negative. For the entirety of FY2010, 89 individuals received PEP, with 28 post occupational exposure, 57 victims of rape and 4 other non occupational including condom failures. All recipients of PEP in FY2010 tested HIV negative before being provided with PEP. Community mobilizers and prevention officers have also started incorporating PEP information in their sessions in the community and at work places.

- All hospitals have an updated PEP registers for occupational exposure and most facilities designed another register for rape survivors which is kept in the casualty department.

- All facilities have constant supply of and easy access to PEP packs. Staff members or rape survivors presenting after hours get PEP from casualty department or one designated ward.

- PEP training is covered in the ART training provided by I-Tech. The community mobilizers have incorporated the importance of PEP after sexual assault or rape in their talk in the community.

Challenges, Constraints and Plans to Overcome Them

- In Onandjokwe, victims of rape still occasionally report to the hospital after the 72 hour window. There is a general lack of awareness among the public of the PEP service available at the hospital. IntraHealth will continue to work to intensify the community awareness efforts of PEP through the prevention program.
- Additionally, while reporting on PEP in general has improved at all the facilities, there is still incomplete reporting of outcomes. Of those who received PEP, it is not known exactly how many seroconverted and how many remained HIV negative. IntraHealth will work with the partners to address this issue and ensure accurate reporting of PEP outcomes.
- Emergency contraception post rape is not permissible within CHS facilities according to Church Doctrine
- Post exposure follow up to detect seroconversion is not completed according to the guidelines

Planned events for the Next Quarter

- Conduct quarterly supportive supervision visits.
- Continue strengthen awareness of PEP in the community and at work places by prevention officers and community mobilizers.
- Strengthen post exposure follow up in accordance with the national guidelines

2.4 Program Area 4: Sexual and Other Behavioral Risk Prevention

IntraHealth recognizes that preventing new HIV infections represents the only long-term, sustainable solution to turn the tide of the HIV epidemic**.** The DHS and other studies as well as the fact that Namibia is experiencing a hyper-epidemic indicate that many citizens are choosing high risk sexual behaviors as a matter of course. Behavior change will be needed on both a personal and community level to affect sustainable change. Successful strategies for fostering effective behavior change require comprehensive, multi-sectoral, complex prevention interventions that address prevailing norms associated with the spread of HIV, while still meeting the needs of people who face elevated risk exposure. IntraHealth accomplishes this through helping individuals, families and communities to maintain environments that enable individuals to make safer choices and to consistently choose healthy behaviors. IntraHealth provides technical assistance, training, quality assurance and mentorship to our sub grantees to help them promote sustained behavior change with their communities.

According to the National Strategic Framework the strategic priority for prevention is to reduce the HIV incidence by 50% by 2015. This will be achieved by implementing interventions that reduce exposure to HIV, reduce the probability of transmission if exposure has occurred, and influence change in social norms, values and practices that prevent adoption of key prevention behaviors. The NSF has prioritized the programs that will be used to deliver the appropriate services to achieve the strategic priority. Social Behavior Change is chief amongst the ten identified programs. IntraHealth prevention programming completed a paradigm shift during this reporting period moving from simply creating awareness to promoting tangible behavior change. IntraHealth supported prevention partners have adapted SBCC approaches and 95% have begun to implement them during this reporting period. This adaptation occurred during the third Q because preparatory trainings were needed as well as organizational shift and change.

IntraHealth's contribution to the promotion of abstinence and sexual fidelity as viable HIV prevention methods is built around two pillars: 1) SBCC activities to increase the practice of abstinence and the delay of sexual debut among primarily younger youth through school-based life skills education and counseling and child centered/focused radio programs and 2) Community awareness sessions designed to "ring the bell" about the high sexual risk level of having multiple concurrent partners.

Pillar one-LLCL's ChildLine School based program

IntraHealth's youth focused partner LifeLine/ChildLine (LLCL) Namibia is at the forefront of national efforts to build communications skills among youth, to enhance emotional intelligence and self-esteem and to increase healthy decision making especially with regards to sexual behavior and HIV prevention. During this reporting period the ChildLine program has been in a transformative phase with strategic programmatic changes being implemented including de-centralization of activities to the Northeast and North central parts of the country and development of the SBCC component of ChildLine.

The SBCC program emerged through a process of meetings between LLCL and IntraHealth. LLCL was initially reticent to change their program approach because of the drastic adjustments IntraHealth was proposing and because they liked their approach. However, through an HIV prevention programming baseline assessment and a SBCC program development training, the entire team was able to embrace the need to change in order to have sustainable impact in their areas of operation. As of end June 2010 ChildLine is carrying out SBCC activities in all of their areas of operation. The transformation was not easy because it necessitated an organizational paradigm shift and this required trainings, meetings, and strategy sessions and finally roll-out. And the challenges are not over-As IntraHealth and LLCL staffs conduct supervision more challenges become apparent. A perfectly functioning SBCC program will take another year to emerge.

For the first half of the year ChildLine continued with its original intervention methodology. This intervention consists of three components: (1) the "Feeling Yes, Feeling No" program; (2) the "Being a Teenager" program; and (3) a teacher sensitization component. The ChildLine team works with students from grades three to seven and grades eight to ten and covers topics of HIV/AIDS, sexual assault and abuse, domestic and gender violence, alcohol and drug abuse, and cross-generational sexual relationships with a specific focus on delivering messages on delaying sexual debut and abstinence. These topics and messages are further supported by LLCL's Uitani radio program. The ChildLine facilitation and presentation methods vary according to the age group.

"Feeling Yes, Feeling No" consists of an age-appropriate puppet show addressing "stranger danger," LLCL's crisis line number, a song teaching children about their bodies and protection of such and saying NO to inappropriate touching. For older children, sexual assault, domestic violence, HIV stigma and discrimination, bullying, feelings identification, reporting abuse and bereavement issues are covered.
"Being a Teenager" is aimed at Grade 8-10 learners (ages 13 to 17 years) and utilizes drama and discussion to promote debate and understanding about HIV prevention, alcohol abuse, cross-generational sex and other risky behaviors. ChildLine further provides sensitization and information sessions for teachers and hostel wardens after school hours geared towards helping them to identify traumatized and/or vulnerable children and how to refer them for help.

The ChildLine School program accomplishment, successes and highlights

- **During Q1** the ChildLine school program wound down due to the commencement of national and final exams. The downtime however was used to visit 4 pre-primary schools and kindergartens. ChildLine staff presented two hour sessions on "Feeling Yes, Feeling No". This is a program delivery method for young children utilizing a puppet show that addresses "stranger danger," teaches LLCL's crisis line number, a song teaching children about their bodies and self protection and saying NO to inappropriate touching.
- **Also in Q1** the Kavango ChildLine team conducted a "camp" for OVC in a rural area. This is an edutainment activity designed to improve the lives of children by strengthening their emotional resilience with coping skills and identifying OVC in need of specific help in order to refer them to the appropriate services. Facilitators use the "Journey of Life" curriculum with the children. IntaHealth's prevention team observed this activity and provided feedback to LLCL on improving the OVC camp initiative.
- **During the second Q** the ChildLine school program kicked off an aggressive schedule with three teams working in Windhoek, Ondangwa and Rundu. The ChildLine facilitators conducted sessions in "Feeling yes/no" and "Being a teenager" and reached a total of 4932 children (2246 male, 2686 female) in 15 schools with AB messages.
- **Also in the 2nd Q** the decentralization of the ChildLine program to the Northeast (NE) regional capitol of the Kavango region, Rundu, was finally completed. This was an efficiency measure proposed originally by IntraHealth over a year ago. The newly placed NE ChildLine program coordinator spent the quarter planning activities, familiarizing herself with the regions and also facilitating program activities. The highlight of the quarter was the training of the newly selected ChildLine volunteers on the program drama scripts. The volunteers then proceeded to perform their scripts to the centre staff who then gave constructive feedback to the team. This proved to be an ideal orientation to the centre staff on ChildLine activities. The NE ChildLine team then proceeded to carry out sessions at 13 schools in this rural, isolated and high prevalence region.
- **In the third quarter** the ChildLine facilitators conducted sessions in "Feeling yes/no" and "Being a teenager" and reached a total of 825 children (404 male, 421 female) in 3 schools with AB messages in Rundu and Windhoek. During May 2010 the ChildLine school program came to a stop due to the closing of the schools for the winter holiday. The downtime was used for data collection and a vulnerable children's holiday camp in Rundu.
- **Also in Q3** the ChildLine team assisted the community teams in Khomas region with data collection for the new SBCC program. Namibia's schools reopened at the end of May, but ChildLine programming was delayed due to the preparatory activities of the new SBCC program which included training on the drivers of the epidemic and IPC materials conducted by the LLCL training team.
- **Quarter 4 marks the full roll out of the SBCC program**

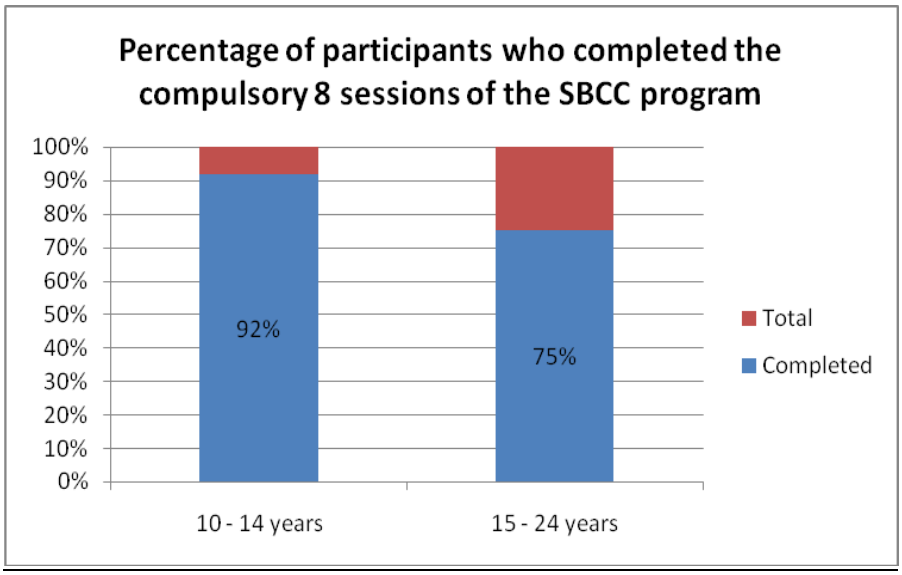
  SBCC sessions commencement (schools program)

  After all the preparatory work, the SBCC sessions could finally commence. The different SBCC teams in the regions followed the same program. Separate programs have been developed for the primary school learners (10 – 14 years) and the secondary school learners (15 – 24 years). The primary school program includes mainly modules on self-esteem and delaying sexual debut. The secondary program includes modules on Risky Sexual Behavior, MCP, Cross generational & Transactional Sex, Alcohol Abuse & HIV and Abstinence.

Region	Age	Male	Female	Total
Khomas, Windhoek	10 - 14 years	67	82	149
	15 - 24 years	74	67	141
North-Central, Ondangwa	10 - 14 years	12	15	27
	15 - 24 years	65	80	145
North-East, Rundu	10 - 14 years	44	42	86
	15 - 24 years	77	85	162
	Total	**339**	**371**	**710**

SBCC sessions completed by regions and age disaggregation

Region, town	Age	Male	Female	Total
Khomas, Windhoek	10 - 14 years	60	77	137
	15 - 24 years	32	38	70
North-Central, Ondangwa	10 - 14 years	12	15	27
	15 - 24 years	65	80	145
North-East, Rundu	10 - 14 years	30	47	77
	15 - 24 years	53	69	122
	Total	**252**	**326**	**578**



Below is an example of the five to eight sessions which an SBCC facilitator might use:

1. Introduction to SBCC
   The main objective of this session is to outline the purpose of SBCC.
2. Value clarification and gender issues
   The objective of this session is to have the participants explore personal values in relation to gender "norms" and cultural expectations. It further explores how certain behavior could expose people to HIV.
3. Self disclosure
   The main objective of this session is to help the participants to conduct a self reflection on their behaviour and identify issues that they need to address. This session is particularly important for HIV prevention as it helps the participants to explore what behaviour could expose them to HIV risk and also how they can seek support for HIV related issues for instance disclosure of HIV positive status to avoid re-infection or infecting others.

4. Personal risk assessment and multiple concurrent partners:
   This session is conducted through a wider collective and open discussion to enable the acquisition of more knowledge on how having many sex partners at the same time increases the risk of HIV/AIDS. This session utilizes the MCP flannelgram to show how HIV spreads within sexual networks.
5. Cross generational sex and transactional sex and delaying of sexual debut:
   This session uses IPC picture codes to raise awareness on the dangers of cross generational sex. For the 15-24, the issue of delaying sexual debut is also addressed.
6. Male circumcision as a HIV prevention strategy:
   The main objective of this session is to highlight the health benefits of male circumcision, clarify what male circumcision entails while at the same time exploring the barriers to male circumcision.
7. Alcohol abuse and condom use:
   This session highlights the dangers of alcohol abuse and how it influences judgement that leads to making wrong decision resulting in alcohol abuse being one of the HIV drivers. The session also emphasizes on the importance of correct and consistent condom use. Condom demonstration is done during this session.
8. Voluntary Counselling Training and People Living with HIV/AIDS:
   The objective of this session is threefold. The first one is to highlight the importance of HIV testing while at the same time exploring with the participants sites where VCT services are provided. The last goal is to have the participants understand the effects and explore ways to address stigma and discrimination related to HIV.

Lifeline's Uitani Radio; accomplishments, successes and highlights

Co-funded by USAID and UNICEF Uitani ChildLine Radio is a participatory radio program run by and for Namibian children. The Uitani team is made up of 52 children aged between 8-16, of which 25 are reporters and 27 are radio actors. The 25 reporters (19 girls, 6 boys), are trained in radio production and interview techniques and record shows every week for Uitani radio. The 27 actors are responsible for radio dramas and public service announcements. Those older than 15 years and exiting the group are absorbed into a children's activist committee called *Lets Realize*.

- **In the first quarter** Uitani ChildLine Radio continued to air 39 one hour shows on four different radio stations (NBC, Omulunga, BASE FM and Fresh FM). The topics were related to social and family issues which cause children distress, including HIV & children, myths about HIV, preparing for exams, stress management, personal hygiene, STI's, fear (how to deal with it), how to study, rape, death and bereavement, dealing with grief, parenting, suicide, and alcohol abuse. These programs are co-produced and presented by children (ages 8-14 years).
- **Also in Q 1** eighteen live broadcasts also occurred, one from Fresh FM and one from Omulunga Radio with the Convention on the Rights of the Child as theme. The others were from the Windhoek show and from the BASE FM birthday barbecue. The English and Afrikaans language shows continued and a radio drama produced by the Uitani kids called *Kids of Kuku Street* began production.
- **In the second quarter** Uitani Radio celebrated its fifth birthday as a By and For children radio station. A UNICEF funded external review of Uitani conducted in 2009 recommended that Uitani should partner with more local children's initiatives and broadcast from sports events in order to reach a broader audience. Uitani radio celebrated its birthday by conducting a live show at the PEPFAR funded Bernard Nordkamp centre (BNC) in Katatura run by Catholic AIDS Action. The BNC children participated in the show and we played fun and educational games and HIV knowledge competitions.
- **Also in the 2nd** Q Uitani held the first production meeting of the year. A review of the progress made to date regarding review recommendations was undertaken and possible changes to the program format, new topics and slots of the show were discussed. Parents of the Uitani kids were also invited and introduced to LLCL's child protection policy.
- **The 3rd quarter** was full on show production- Radio aired 65 one hour shows on four different radio stations (NBC, Omulunga, BASE FM and Fresh FM).
- **In the 4rth quarter** Uitani ChildLine Radio continued to air 63 one hour shows on four different radio stations (NBC, Omulunga, BASE FM and Fresh FM). The topics related to issues children may be faced with (i.e. how to study, Careers, stress management, teenage pregnancies, being afraid, bullies, health and

cleanliness, fashion, poverty, saying No to sex in relationships, Day of the Namibian Child, domestic violence, single parents, siblings, suicide, honesty & deceit and sugar daddies). These programs were co-produced and presented by children (ages 8-14 years).

Pillar two-Ringing the bell and promoting change regarding MCP

IntraHealth is a key partner in the MCP task force and our partners are at the forefront of MCP awareness implementation. The New Start community mobilizers and FBH based HIV prevention officers were the first health activators in the country to be trained on and to utilize the MCP flannel gram as an IPC tool. These activities were carried out in 10 of 13 regions by 25 activators.

The IntraHealth prevention team adapted this IPC tool from PSI Mozambique materials to contribute to the overall MCP campaign in the country. Consequently a series of trainings was rolled out for various PEPFAR partner organizations to equip them to use the tool with their communities. IntraHealth both participated in the curriculum design and in the training roll-out.

No. of MCP sessions conducted & people reached (18 sites)				
	# of sessions	# of people reached		
		MALE	FEMALE	TOTAL
October 2009	33	588	736	1324
November 2009	4	179	307	486
December 2009	3	20	39	59
January 2010	26	126	162	288
February 2010	27	229	325	554
March 2010	13	124	205	329
April 2010	27	292	463	755
May 2010	20	287	295	582
June 2010	37	287	250	537
July 2010	29	170	299	469
August 2010				0
September 2010				0
October 2010				0
November 2010				0
December 2010				0
	219	2302	3081	5383

IntraHealth supported community outreach interventions

IntraHealth partners contributed to the NSF and Other Prevention targets and goals by conducting a plethora of community outreach interventions during this reporting period including both small group and community mobilization events.

LLCL's community activator program accomplishments, highlights and successes

- **During quarter one** the Kavango team was asked by a Baptist church to mobilize their parishioners about HIV. The pastor admonished the team NOT to talk about condoms. IntraHealth had provided training to the team in the use of an MCP focused interactive video which they employed which elicted fervent participation. Among the feedback obtained from the 30 participants (14 Male and 16 female) was that materials items such as food, cash, alcohol, car, cell phone were regularly used to obtain sex.
- **Also in Q 1**, and far to the Northwest, the LLCL team conducted an educational session with a group of 24 pregnant women at Ondobe clinic on condoms and other prevention measures that an individual can use to prevent herself from being infected by HIV virus and other STDs-this was a 2nd meeting with this group of women. The discussion centered on HIV prevention methods and the importance of HIV testing. The women shared many worries about their ability to protect themselves. They further went on say that their men are involved in multiple partner relationships specifically because their wives become pregnant-and sadly because they are regular and/or cohabitating partners the men refuse to sue condoms.
- **During the 2nd quarter** in a deeply rural Kavango community a surprisingly open discussion was conducted about alcohol and ARV adherence. It is believed that this is because of the leadership and acceptance demonstrated by the headman who asked LLCL to talk on this subject. As is so common in this, the poorest region in the country, participants asked "what if I do not have food-how can I take the ARV's?" The team educated the audience on the importance of taking the pills on time, in prescribed dosages and in the correct manner.
- **Also during the 2nd quarter** the North central team reached out to the politically significant area of Okahao. Okahao shocked the nation when the last sentinel results were released because it was the first time to be included in the study and the prevalence came in at 27.4, the second highest in the country. The LLCL team was invited by the traditional leaders to discuss the high levels of gender based violence in the area. This is a positive sign that the opinion leaders there, who wield significant power, are looking for change from their constituents and asking for help. The presentation resulted in them being invited to present to the Kings Palace the next day.The senior chief introduced the LLCL team to the King and the headman. The team then explained GBV and male norms. Participants were actively listening and participating in identifying signs and symptoms of abuse. The team accentuated the tendency of men to hold their feelings in and then release them inappropriately and dangerously. The link between the abuse of power and violence and HIV was made.
- **During the 3rd quarter** The LLCL teams were deeply ensconced in project assessment activities and SBCC surveys countrywide. This was a challenging exercise as some of the community members were surprised by the personal nature of the questions asked.
- **Also during the 3rd** Q the Northwest team began SBCC work using the new small group methodology. This is a marked departure for LLCL and will take some time to be perfected. In Okahao the first week was a struggle. Here the community members did not understand the need for 8 sessions (and this is the area which came in with 27.4% prev in the sentinel study). However, the team campaigned with the headman who explained it to his constituents. Three groups are now operating.
- **Also in the 3rd quarter** In the Oshana region LLCL teams continued to fill a valuable gap identified by the Ondangwa Health Center. The nurses do not have the time or the education to give varied HIV information. The LLCL community activators are filling that gap on Tuesday and Thursday mornings by presenting to patients on HIV prevention, treatment and care. Below are some of the questions asked during these sessions which indicate the complex training community mobilization staff needs in order to do their work.

1. *Where one can report if a child is being sexual abused?*
2. *Have you had an HIV test yourself?*
3. *Can the baby get infected through breastfeeding if the mother is HIV positive?*
4. *If my husband is abusing me, can you come to our house and talk to my husband?*
5. *Is it only women who are abused or men also being abused?*
6. *What is CD4 count?*
7. *When can one start with ARV?*
8. *Can I take ARV drugs if I am on other drugs?*

- **Quarter 3-** the LLCL team reached out to a marginalized San community. During this activity alcohol abuse and the link to HIV/AIDS spread dominated the discussion. The San elders presented the team with a list of problems such as lack of food, mosquito nets and basic healthcare. The community further mentioned that they feel that drinking traditionally made alcohol is the only way to fill up their stomachs since there is not

enough food for them. The male members were honest in describing that bouts of drinking are usually followed by unprotected sex which is "enjoyable and good for human natural production". They reported believing that drinking increases their ability to conceive which makes them better men. But the women had a different take on the alcohol abuse- they shared that after drinking alcohol men won't eat, insult others and beat their wives.

- **Quarter four marked the official beginning of LLCL's community based SBCC programming roll out.**
- LLCL Kavango SBCC community programming:
- The first cohort had 11 communities, 4 of which were in the 15-24 age categories while the other 7 communities had participants in the 25+ age category. In the second cohort, only 8 communities were targeted. 3 communities had participants in the 15-24 age category while the other 5 had participants in the 25+ category. Changes in the program to address quality issues were done in the second cohort by incorporating the lessons learnt during the trainings and supervision. For instance, IntraHealth recommended that there was a need to change the facilitation approach from mobilization to interpersonal communication in order to engage the participants in the sessions.

Table 1

SITE	*AGE GROUPS*	*CATEGORY*
	Cohort 1	Cohort 2
Sauyemwa	15-24	25+
Tuhingireni	15-24	25+
Sun City 2	15-24	No facilitators
Kehemu	15-24	25+
Kakuro	25+	No participants
Siudiva	25+	No participants
Muhopi	25+	25+
Mururani 1	25+	15-24
Mururani 2	25+	15-24
Sun City (Ndama)	25+	15-24
Utokota	25+	25+

- **LLCL North Central SBCC community programming**
  The NC LLCL center began the SBCC work with a training of staff. Preparations for the program were done through facilitation training well ahead of the actual implementation and all of the volunteers and 6 staff members were involved in this exercise. The training was facilitated by two trainers from LLCL national office and a regional community activator. 39 groups were formed throughout the Northern regions. All groups have successfully completed their 8 sessions for SBCC intervention although not all participants completed the eight sessions in full. 24 volunteer facilitators facilitated the SBCC presentations to the identified communities.
- **LLCL Khomas region SBCC community programming**
  In August / September 10 SBCC volunteer facilitators have been conducting the sessions. A total of 187 participants have been registered and of this 187 a total of 155 participants have completed all 8 sessions.

FBH based HIV prevention and SBCC program highlights and successes

IntraHealth is tasked to build the capacity of six FBH to provide high quality HIV prevention services. This capacity building involves increasing, improving, standardizing and integration of prevention activities at, in the vicinity of and emanating from the Mission hospitals under their stewardship. Activities include providing training, quality assurance, oversight, mentorship and supervision and teaching partners to use accurate monitoring, evaluation and reporting on the activities. IH assists partners to strengthen, focus and improve existing delivery methods making the intervention more impactful and increasing the sustainability of the hospitals overall response to the HIV epidemic.

During this reporting period at Oshikuku, Nyangana, Andara, Rehoboth, Odibo and Onandjokwe FBH, HIV prevention and BCC officers (POs) strengthened each hospitals ability to integrate HIV prevention messaging into all provider areas through providing educational interventions to staff focusing on the drivers of the epidemic. With the change in indicators and increased focus on quality, dosage and behavior change, the POs began shifting from providing

information alone in a once off session or group to providing a series of small group educational sessions to targeted recipients. The POs started with hospital staff and are systematically continuing until all staff has received the 8 session course. They will then branch out to providing this service to patient groups and community members. Some PO's are doing both at the same time.

By their nature hospitals systems and staff are not open to such interventions. Stigma and discrimination are abnormally high in medical settings (though anecdotally it is reported to be improving) and health care providers are often unwilling to show that they do not know everything about healthcare; hence there are compliance challenges. The hospital structures has been bombarded over the years with "new" work related to the HIV epidemic i.e. PMTCT, HAART and now MC and PwP. When you couple these factors with high patient loads, low morale and perceived low pay you do not have an enabling environment for learning and integration of HIV messaging. But the opportunities to reach people in this setting are unparalleled therefore the effort continues-and is paying off. The year has been full of the mentioned challenges but also solid successes. The IntraHealth prevention team works hard to bring the hospital management onto the "team" so that they can drive the integration effort and also ensure it remains sustainable.

- **During the first quarter** at Catholic Health Services (CHS) Nyangana Mission Hospital the PO begun the aspirational work and fielded a major success. This gentleman gathered together, with the strong support of the hospital matron and PMO, a group of interested staff and provided them with a series of educational sessions. This writer observed one of the sessions-there were 26 participants; male and female, a mixed group of nurses, support staff including a nun and one doctor. What was interesting to see is that they have begun to speak in terms of behavior change and use those words "we have to get our husbands to change their behavior" indicating that they get it-things cannot stay the same whether rooted in culture or religion if the epidemic is to be turned back. The culmination of the series of sessions was inspirational to the group and they now want to continue. The group held a "graduation" ceremony which was attended by the Kavango regional health director and members of her team who travelled just to witness the graduation and hand out certificates provided by IntraHealth.
- **Also during the first quarter** a prevention workshop was conducted at CHS's Andara Mission hospital on 16-17 November with 41 members of the HIV support group. Topics covered were A, B, C, D prevention, Brief Motivational Intervention (BMI), family planning, nutrition, TB/HIV, treatment literacy and Multiple Concurrent Partnerships (MCP). The PMO delivered the keynote speech.

PO at Andara hospital conducting the MCP flannlegram with support group members

- **During the second quarter** at Lutheran Medical Services' Onandjokwe hospital, 144 participants completed 5 to 8 small group sessions focusing on MCP, STI, alcohol abuse, gender base violence, male norms and male circumcision. Getting the exact same number of individuals attending in the same group remains a challenge. The strict session registers helped to keep track of attendance. 130 sessions were also held with individuals on the varied topics including BMI, GBV, Male norms and other prevention information.
- **Also during the 2nd quarter** at LMS, the Prevention officer and the hospital Peace Corps volunteer began mobilizing the community to access male circumcision services. Posters were distributed in Ondangwa town, barber shops, bars and sessions were conducted with teachers of 5 schools on male circumcision and other preventative methods.

- **Also in the 2nd quarter** at CHS's St Martin's Hospital in Oshikuku the PO made headway with sessions on Gender Reproductive Health. This began as a result of the PO and her PCV attending an IntraHealth sponsored two week gender course. The focus was on assisting communities to address gender inequality and encourage communities to start to address gender disparities and allow for women to have a meaningful contribution concerning sexuality, their reproductive health and economical status. Through small group sessions the
- participants are came to realize how gender inequities imbedded in cultural practices, accepted by society and cultural groups, have contributed to the spread of HIV. The groups in Oshikuku have said it is very difficult to change what has become culture to them but they were all willing to discuss and were all hopeful that they will start to make and change especially with their children. Condom negotiation was discussed and ageed by the group as the only way amongst those sexually active to minimize the spread of HIV. Great importance is attached to the culture but at the same time they realize that the battle against the spread of HIV must be won.
- **During the 3rd quarter** The PO worked closely with hospital staff and a dedicated Peace Corps volunteer to provide small and large group sessions in and around Shanamatangu. 55 sessions were conducted reaching 702 people through small group and large group interventions. 170 of these participants attended individual sessions and 372 completed 5 to 8 sessions on the drivers of the epidemic using the discussion guide and IPC materials.
- **Also in the 3rd quarter** the Onandjokwe prevention team conducted three male only sessions which we were hailed by participants as very relevant to their daily struggles. Focus was on male norms, male circumcision, gender base violence, MCP and alcohol abuse and the participants demonstrated intense interest in the program. The team will follow up with monthly discussions with their traditional councilor to look for tangible solution to their problems.
- **Also in the 3rd quarter** at Oshikuku hospital the prevention officer made significant in-roads conducting 40 sessions and graduating 38 participants-this means these participants went through 5-8 sessions. Topics covered were MCP through the flannelgram, gender +HIV, HIV risk factors, cross-gen and transactional sex, HCT, condom use and alcohol and HIV. She struggled at first but after the IntraHealth sponsored and facilitated prevention round table, management took control and began to insist that staff attend-this is the precise desired outcome in terms of sustainability. Participants included HAART nurses, VCT counselors and Catholic mission employees. The PO admits to being initially nervous to educate nurses and this is a challenging theme at health care facilities. The refrain from health care workers is "We already know everything, we are already doing prevention". But she found the contrary and so did participants. PO reports surprisingly low level of understanding on condom use, viremia +progression and discordancy. As recommended Oshikuku had a graduation session for participants which inspired other staff to want to attend-she now has a waiting list.
- **Also in the 3rd quarter** at Nyangana hospital the prevention officer continues to operate in full swing with enthusiastic support from management. He runs four groups at a time and continues to screen pre-HAART patients and to help them prepare prevention plans. He also has started a group at the Ndyona secondary school and will begin more community interventions once he has "finished" hospital staff. The new PMO at Nyangana luckily attended the prevention round table and he is very keen on developing this position. Nyangana is in the pipeline to become an MC pilot site and the PO will begin demand creation mobilization when there are more trained personnel to fill the demand.
- **Also in the 3rd quarter** at AMS's Odibo Hospital the PO has started 8 small groups with St. Mary's hospital staff, St. Mary's secondary school both boys and girls, with community members and with the Namibian police at Oshikango.162 participants were registered with 110 participants completing the series of 8 HIV prevention sessions. Topics were MCP, HIV and alcohol, MC, couple communication, trans generational sex, transactional sex, STI`s and gender based violence. Some graduates have asked to go through the cycle again. 13 new condom outlets were identified, in attempt to address the challenge that some communities especially those at the borders do not have access to existing condom outlet points.
- **Oshikuku** conducted 1 male conference in the last quarter and 137 males attended. 20 males and 109 females completed 8 SBCC sessions in the Q 4. One alcohol support group was formed in this Q 4 comprising of 2 males and 17 females.
- **In Odibo** much success has been achieved with the pregnant women attending ANC appointments. The PO capitalizes on this opportunity to gather them and discuss HIV prevention, HIV risk assessment, GBV, femidom demonstrations and communication issues. They have engaged well with the concepts and now continue to come even after delivery for more sessions and discussions on HIV prevention issues.

- **CHS's St Mary's Rehoboth** also achieved a breakthrough with the ANC clients and provided HIV prevention sessions managing to extend to the much needed PMTCT Plus. The sexual partners are also coming with them which shows that the topics discussed with them on male engagement are being talked about at home and in the community. 8 males and 118 females completed 8 SBCC sessions in Q 4
- **Nyangana PO** started a 'Male only' group of 17 participants soon after the August IntraHealth sponsored Male Engagement training and they will graduate end of October after 8-10 sessions. The topics being covered are GBV, cultural norms and values, 'Persons and The Things' and 'The Gender Fish Bowl' as such topics facilitate for discussions. 38 males and 50 females completed 8 SBCC sessions in Q 4.
- **Onandjokwe P O** started visiting shebeens with the hope of meeting those who have a problem with alcohol and need help but have no knowledge of it or how to go about it. It was a challenge to begin with, with the proprietors refusing to reduce the volume of the juke boxes but finally they agreed and though the groups were erratic in attendance ranging from 5-8 participants, she managed to complete SBCC sessions with them with the help of strict register keeping. Three were finally referred to the social worker two for rehabilitation for help with alcohol abuse and 1 for GBV perpetrated by the boyfriend against her.
- Another alcohol support group was also started in Q 4 in **CHS's Andara hospital**. 14 males and 11 females also completed 8 SBCC sessions in Q 4.

LLCL Center and community based generic counseling

Stronger and emotionally centered communities are better able to enact change and support members to change their behavior. LLCL provides general counseling services to people in emotional need relying on a well trained cadre of volunteers. LLCL Namibia manages one independent counseling service centre situated in Windhoek and two outreach centers in Namibia's populace Northwest and Northeast regions with a combined population of almost 300,000. Emotional health is a pre-requisite to the success of HIV prevention and care activities. Furthermore generic counseling offers a one-on-one opportunity to review prevention and care options and to refer clients for services. Clients who present for VCT services at LLCL New Start services can be referred for generic counseling when VCT counselors identify underlying social/emotional issues putting their client at continuing risk.

Generic counseling centers; accomplishments + highlights

- **During the first quarter** 173 clients received counseling at 15 counseling points in the Northeast region. These points include the LLCL center, outreach points as well and schools drop in counseling. Counseling issues reported range HIV/AIDS and related issues, relationships problems, education, sexual violence and substance abuse.
- **During the second quarter** in the Northeast a total of 126 clients were counseled. Problem categories presented ranged from HIV and related issues, relationships, alcohol abuse, physical health and child abuse. The highest category problem received was HIV. The category with the second number of cases was physical health cases followed by child abuse.
  In the 1rst and 2nd quarters generic counseling proceeded at all the centers in the four Northern regions. The volunteer counselors provided counseling to 403 females and 170 males (743)
  During the 1rst and 2nd quarters the LLCL Khomas regional counseling center was very busy. The activities that take place under the hat of the Windhoek Centre include generic telephone counseling, generic face to face counseling, community outreach and community counseling. During this reporting period 18 volunteers carried out these activities.
- In November the Windhoek LLCL counseling department moved to a new building situated in a central area. A second counselor was appointed for the crisis line. A suicide-prevention mini workshop was held for counselors and volunteers, in order to equip them with skills, before the holiday season started. As is common during the Christmas holiday more clients presented with problems with loneliness and depression. Both counseling and supervision of counselors continued at the Windhoek centre as well as at the Katatura center. The Manager has set aside two half days for supervision of volunteers and counselors.
- During the second quarter problem categories included HIV related issues, legal issues, court cases, child maintenance, school problems, bullying, witchcraft, peer pressure, lack of finances, sexuality, teenage angst,

physical health, relationships, child abuse, psychological health, depression, loneliness. Referrals were made to New Start, MGECW – social worker + MoHSS – state clinic.

- **In the 3rd quarter** NW office activities included volunteer supervision, in-service training on suicide for volunteers, and on-going provision of generic counseling services to inhabitants of the four Northern regions. 29 Volunteers received counseling supervision from LLCL staff where they discussed how to handle difficult cases. An emerging concern is the amount of cases which involve crime (sexual abuse, arson, theft, domestic violence). Kavango center- 153 people received generic counseling services at the LLCL NE center. Windhoek center-126 people received generic counseling at the Khomas regional counseling points.
- **In the 4rth quarter** The Windhoek Counseling Centre reported a total of 107 counseling cases. From the 107 cases, 77 were first time female clients with major problem categories being intimate relationship problems/couple communication, multiple concurrent partnerships and emotional abuse and family conflict. An additional 7 cases were recorded as follow – up cases. From the 107 cases, 30 were first time male clients with the major problems being anxiety, multiple concurrent partnerships, HIV / AIDS – testing, and discrimination and emotional abuse. There were 3 follow – ups recorded with the males.
- **Also in the 4rth quarter at the Northeast center** a total of 149 new and 10 follow up cases received generic counseling at various sites. The cases have been progressively increasing with 30 new cases and 1 follow up case in July, 34 new clients and 2 follow up in August, and 85 new and 7 follow up cases in September. Among the highest category problems received were relationship, physical health, mental health and relationship related.
- **4rth quarter Northcentral:** Since the program inception of SBCC a low counseling figure has been recorded because the volunteers previously providing counseling are now providing SBCC. But the NC team did provide clinical supervision sessions for counselors at four counseling points. During these sessions volunteer counselors are given opportunity to present their difficult cases. The social worker may provide assistance where it is needed and make sure that the right procedures have been followed especial when referrals are required. This quarter was overwhelmed by the number of suicide cases which is a disturbing trend. Examples of cases LLCL volunteer counselors are faced with:

1) A case was presented of a 36 year old married women who is HIV+ and living with her husband, also HIV+. Her husband refuses to use a condom. A lively discussion ensued on the impact of culture on the transmission of HIV/AIDS and how powerless women are at times. Because the woman came in for the counseling alone, possible options and risks were discussed with her.
2) Another case was presented where a 52 year an old woman was married to an abusive partner. He abused alcohol as well as beat her regularly. She went to her in-laws and on her return found the husband had committed suicide by hanging himself. The wife is suffering from self blame and was devastated, overwhelmed and in shock. Further counseling sessions were arranged after the funeral for bereavement counseling.
3) A volunteer at Ondangwa narrated a case she dealt with regarding a father who sent his children to sleep at the neighbors. When the children returned home, they found the father's body hanging in the house. The three children were extremely traumatized by this as well as struggling to come to terms with the grief. Unfortunately the children would go back to Windhoek after the funeral, but t the case would be referred to Windhoek office for further follow up. The children and their mother were later seen by the regional coordinator for their details and the case was referred to the social worker in Windhoek.

<u>SBCC program evaluation</u>

During this reporting period, IntraHealth with collaboration with C-Change built our partners capacity to evaluate their programs, re-program according to evidence and to make evidence based decisions in program design and intervention.

The LLCL staff and FBH prevention officers and FBH head office staff received a series of three trainings presented by Mr. Joshua Volle of C-Change USA. IntraHealth staff provided approximately 2 weeks of mentoring and assistance particularly in the areas of data analysis and report compilation. Overall this was a positive experience for all and should contribute to the overall strengthening if our partners. However, there are some lessons learned which the IntraHealth team is considering as we move into the next reporting period.

The program assessments began mid-year in all six FBH sites and LLCL Schools and Community Programs. The rationale was to collect direct information from different age groups (10-14 years,15-24 and 18+)on their individual knowledge, attitudes, beliefs, norms, values, perceptions and behaviors towards HIV transmission and sexual behaviors before engaging them in SBCC interventions. These assessments are designed to provide an opportunity to identify unanticipated outcomes on behaviors and track actions to correct those behavior, attitude and beliefs identified.

What became clear as the IntraHealth team went out into the field to provide TA was that the lack or sub-standard level of basic education which our partner staff have was an obstacle to full success. These staff probably needed a more basic course and the trainings could have been better closer together.

That said, our partner organizations learned a great deal about the need for evidence when planning program interventions, basics on tools and data analysis, how to utilize critical thinking and about the importance of evaluation and using one's own data to inform decision making.
There is a road ahead still before the FBH and LLCL staff can use this evaluation-we are still in the learning phase. But the IntraHealth prevention team is highly committed to seeing this through and providing the TA these organizations need to fully integrate evaluation and evidence based decision making into their program.

IntraHealth Prevention office activities

- The IH prevention team has completed a 'Dual Protection' counseling tool featuring the First lady of Namibia. The text was agreed upon with Mrs. Pohamba and approved by the MoHSS family planning unit and the photo taken. A success is the very strong support from the family planning unit who will also test this tool concurrently with IH.
- The standardized prevention performance support tools were finalized during this reporting period and in use. The same checklists that the IH Support team uses with the partners was discussed with them and adapted by the partners for use for support and documentation monthly.
- A prevention 'Round Table' meeting was convened with FBH management and the HIV prevention officers to assist with in depth understanding of the jobs duties and what is required of the Heads to expedite their work.
- Training was conducted for New Start community mobilizers and facility based prevention officers on the use of the recently developed IPC tools and the laminated A3 size cue card to aid with accuracy of facts a. "AIDS+Me" as facilitated by Positive Vibes, provided the Three and a Half Lives of Fillip Wetu DVD and Facilitation Manual for each participant to now go and also do small group facilitation.
- IH M&E team together with prevention team developed and tested the HIV prevention session registers for use with participants for tracking HIV SBCC session attendance.
- IntraHealth sponsored an M&E data analysis training in preparation for the HIV behavioral baseline program assessments. Facilitators were from C-Change and participants included the IH team, partners and FBH and LLCL staff.
- IntraHealth partners attended joint assessment and planning training on a proposed HIV discussion guide. C-Change capitalized on FBH and LLCL staff's capabilities by pilot training them with the new tool. IH prevention team then planned the roll out tof small group sessions with partner staff.
- The male focused HCT demand creation campaign was finalized during this reporting period and much time spent on this and as well preparing for the launch. The president of Namibia has indicated his support for campaign messages and a message from him was read on his behalf by the deputy minister of Health-this was launched in the 3rdQ.
- Performance support/QA/mentoring visits were conducted to all FBH and New Start centers quarterly.
- The team attended a prevention training sponsored by the CDC
- EngenderHealth trained the new IH team members and CHS staff in an 'extended' Male Engagement group facilitation and campaigning skills.
- IntraHealth prevention staff contributed to the development of the PWP curriculum as part of a joint effort with I-TECH and other partners. Final pretesting was done in Gobabis with the nurses of the Omaheke region. The 'Community Piece' for the facility based prevention officers, non medical cadres, is still to be extracted from this completed work.
- IntraHealth contributed to the training of NGO's and FBO's in the use of the MCP flannelgram.

- Polytechnic of Namibia Peer Educators and HIV Awareness Students Club were trained for 5 days in various HIV Prevention topics including; VCT, MC, ARV's,' Three and a Half Lives of Fillip Wetu', Alcohol and Lifestyle & choice discussions.
- IntraHealth staff regularly participated in the prevention and MC TAC's and MCP, IEC and PwP TWG'.
- IntraHealth is spearheading a joint training initiative for Namibia's State House, the seat of the Presidency. Partners will include MoHSS and Walvis Bay Corridor group. This was suggested by the First Lady during the development of the dual protection counseling tool. Security procedures took a great amount of time but implementation is near to starting.

Challenges which are being managed:

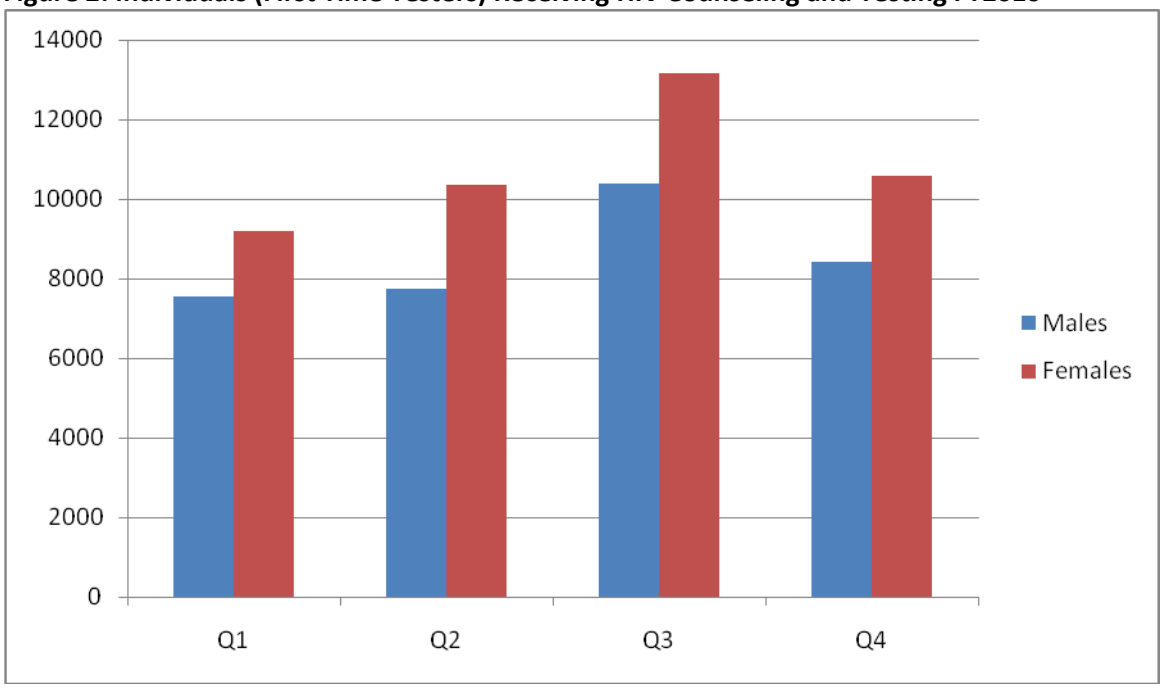
- Trainings are usually conducted in English in order to reach all ethnic groups. However, for many learning in English is a struggle.
- Decentralization of the ChildLine program presents space challenges. As a result of logistical problems the team of North Central will remain mobile with Windhoek as their base.
- Time constraints in SBCC presentation- principals usually give the teams the "life skills" class time-it is not enough to present a full session.
- Seasonal flooding hampers implementation during the second quarter
- Implementing partners continue to need a significant level of support/mentorship/on-site training as issues are complex and staff under educated.
- Ensuring quality means intense supervision. Hospitals do not have staff who have the time to ensure quality of prevention interventions.
- Getting adult participants to attend 5-8 classes can be a struggle as their live are full of challenges which they must attend to.
- PwP still stalled somewhere in the system.
- Unavailability of facilitators in some locations has resulted in low coverage leaving one community not being covered in the second cohort.
- Schools operate on different timetables (5 or 7 day cycles).
- Lack of space to conduct the sessions at schools (not enough empty classrooms)
- Time constraints at the schools (only 30 – 35 minutes for a session).
- Classroom size in North Central & North East in general very big (50 – 60 learners in some class).
- Additional training for LLCL volunteers needed (PG, BC, CC & HIV)
- The LLCL training team itself has training needs which IntraHealth discovered in the course of training exercises.
- LLCL continues to have supervision challenges as their programming is spread thin.
- LLCL remain without a NW regional coordinator.
- All IntraHealth prevention partners are concerned about ability to reach targets. It took the first half of the year to make the shift to SBCC programming and also involved training. As they can only count a person after graduation, many hours are expended with a person before they can be counted. All of this affects the program ability to reach the agreed upon targets. Please note, the targets were agreed upon provisionally in that we made clear that we were not sure, for the mentioned reasons, how the year would proceed.
- SBCC interventions are more expensive. LLCL for instance, used to only pay their volunteers for travel. Now they are paying them very regularly to conduct small groups.
- Hospital staff seem to be inherently resistant to new interventions and also stigma is high which makes staff afraid to participate in educational sessions
- SBCC facilitators struggle to keep attendance-most participants are adults and things happen making them unable to attend (cultivating, funerals, childcare, illness, transport problems)
- More training is needed for SBCC facilitators (HIV basics and facilitation)
- SBCC programming and IPC tools use requires a careful supervisory mechanism. LLCL does not have this in place yet.
- The program evaluation tool is challenging for people to use.
- The classes are divided up into two groups and to find space for the second group is sometimes problematic, but for now meet outside.
- Fresh FM is not broadcasting the shows in the agreed slot, but earlier in the morning which makes it difficult for children to tune in.

2.5 Program Area 5: Counseling and Testing (HCT)

The IntraHealth-supported HCT program continues to run successfully and has experienced success in scaling up outreach testing services in conjunction with the MoHSS. During FY2010 the highest influx of clients was observed in Quarter 3 where 23528 new testers received counseling, testing and received their results (see *figure 2* below).

During the fourth quarter of FY2010, 20,536 individuals received counseling, testing and received their test results, bringing the total for FY2010 to 84,710. Of those who received counseling and testing in the fourth quarter 19,003 (92.5 %) were first time testers, making the total number of first time testers for FY2010 77,360 individuals which represents an achievement of 107% of the FY2010 target of 72,000**.** IntraHealth has reached its VCT target for FY2010. The number of couples receiving counseling during the quarter was 2,661 (14%) of the total number of people counseled in the quarter, which brings the yearly total to 9,546 (12.3%). This amount exceeded the set target of 9% for this fiscal year. During the last quarter, 10,575 (55.6 %) females and 8,428 (44.4%) men were tested. The total number of individuals that tested HIV positive during the fourth quarter were 1,712, with females accounting for 59% of those who tested positive and the remaining 41% consisting of males (see *figure 2* below). In FY2010, 43,254 (56 %) females and 34,106 (44 %) men were tested, of which 6,909 (9%) tested HIV positive (59% females and 41% males).

Figure 2: Individuals (First Time Testers) Receiving HIV Counseling and Testing FY2010



Accomplishments & Successes

- *Scale up Outreach counselling and testing:* It was noted that there was a very high HIV Counselling and testing acceptance rate in all the centres. Counselling and testing was scaled up in hard to reach areas especially the places where MoHSS had not rolled out the Rapid Testing (RT) services. During this quarter a number of Outreach counseling and testing activities were conducted by various New Start centers nation-wide. These activities increased the number of clients counseled and tested. In Nyangana, Onandjokwe, Rehoboth, Oshikuku, Odibo, Rundu, Oshikango, Outapi , for example , to mention just a few, outreach initiative resulted in very high numbers of clients tested surpassing their targets. This was due to the intensified community mobilization strategy which was supported by committed and dedicated staff with good leadership. These successes can be attributed to the presence of the two IntraHealth regional offices as they have established rapport with the MoHSS Regional Management Teams (RMTs) which enabled more sites to be certified as outreach counseling and testing sites.

- *Scale –up opening VCT centres on Saturdays or extending working hours:* Some New Start centres such as CBD has extended working hours, while CCN has been operating on Saturdays to accommodate clients

seeking counselling and testing services. In centres where opening on weekends or extended hours did not yield much client flow, the decision was made to not continue with this practice as it was not cost efficient.

- *Quality of HCT Services:* Client exit interviews and comments book are currently being used in most centers to assess the client's perception of the HCT services being provided and these have shown high client satisfaction particularly with reduced waiting times.

- *Quality Assurance (QA):* The QA support and supervisory visits were successfully conducted to all centers for both HIV counseling and RT. Certification of three HIV Rapid Testing outreach points in Andara and two in Nyangana facilitated by cultivating good partnership with RMT and NIP. The certification of the ELCAP Mobile testing van by NIP, facilitated by IntraHealth yielded good results as more clients were reached through mobile testing in hard to reach places and HIV positive clients were referred for care treatment and support to the health care facilities.

- *Collaborative activities:* IntraHealth continued to support the MoHSS through technical assistance in HCT activities such as the review of the ACTS Protocol in the HCT National Guidelines which were finalized.

- *Support and organize National Testing Days:* All new start centers participated in the National Testing Day activities with MoHSS. IntraHealth staff participated in the planning and conduct of the NTDs including development of the M&E tools.

- *Collaboration with MoHSS:* IntraHealth spearheaded the collaborative activity towards the drafting of the Bi-directional referral network system with other role players to facilitate the smooth linkage to care, treatment and support for clients that are referred from the VCT centers to other services for the continuum of care. A draft document has since been developed and awaits review and finalization by the MoHSS and its stakeholders.

- *High rate of testing among couples:* Despite this being a challenge over the past quarter, it is interesting to note that IntraHealth and its partners managed to see more couples in FY2010 as compared to the previous year (12.3% in FY2010 compared to 7% in FY2009). This increase in testing successfully exceeded our initial couple's counseling target by 3.3%, and can be attributed to the mobilization during outreach and NTD events.

- *Partnership with SCMS:* IntraHealth had a successful year of working with SCMS in terms of procurement of HIV Rapid Test Kits and supplies; this has resulted in our new start centers achieving high testing rates due to adequate stock level maintenance as RT services were not interrupted.

- *Performance Improvement Approach Implementation:* This approach was implemented following the workshop which took place in June 2010. Some centers, such as Andara, that implemented this approach were able to identify their gaps in relation to performance and implement the best interventions to close up the gaps likely to impede attainment of desired objectives.

- *Linked Services:* All the New Start centers continued to offer symptom screening for TB and STI with appropriate referrals.

Community Mobilization

First and second quarters

New Start community mobilizers were very active during this reporting period with the majority responding to the call to intensify their focus on men as the STRONG campaign is close to completion. There was also a focus on MARPS.

- At Kalayi border post on the banks of the Kavango River and a gateway between Angola and Kavango region, the CM mobilized the assembled travelers, river taxi drivers and uniformed services. The is an informal

though busy post as people living on either side of the border share a common language and family in both countries. Additionally, Rundu is basically a supply post for the development going on in that part of Angola and there is a constant flow of commerce and business people. The CM discussed the importance of HIV testing, risks associated with MCP and transactional sex. Eighteen males and twelve females participated in this mobilization. The CM noticed a low risk perception amongst the Angolans.

- In response to a request from the Student Representative Council at the Rundu College of Education an educational session was conducted at the college with both administrative staff and students. The student's sited travel challenges as the reason why few are accessing HCT. But there was also concern voiced about after services; would those who test positive receive counseling, ARV's and other services? The New Start centre responded by arranging an outreach testing event there.
- The Superior Security Company in Rundu arranged for the CM to educate their officers about HCT during daily line-up. The guards were extremely attentive and had numerous questions. Of note, one of the guards is a member of the post test club and she encouraged her colleagues to know their status as this empowered them to make informed decisions about their lives. A particularly hot discussion was around PMTCT and how an HIV+ couple can give birth to a negative child. This activity reached 18 males and 4 females.
- Independent Security was also mobilized through 2 separate meetings designed to reach both day and night shifts. The guards were encouraged to come for the HCT and were informed that the centre would fast track them to avoid long waiting periods. During the activity, men were encouraged to be responsible for their health and that of their families. Men were advised to go for HCT now and not wait until they are bed ridden or too sick before seeking treatment.
- The CM, according to his mandate to reach out to MARPS, joined forces with a Namibian Defense Force's football team to mobilize the soldiers to access HCT and change risky behaviors. The activity was conducted after their morning exercise and the team members were told to encourage and support each other to go for HIV test. The players were also encouraged to fight against HIV by adopting behavior that included condom use and avoiding multiple concurrent partners. About twenty three (23) male were mobilized at this meeting. A similar activity was conducted with three other local football teams reaching 63 men in all. A related activity was conducted with CUCA tops team where 19 male participants were reached. Of interest this team used to be managed by a USAID HCN who remains their inspiration though she dies 3 years ago.
- An awareness and outreach testing event was conducted at UNAM in March. The response was mixed with hundreds of students accessing information but few ready to actually get a test. It is surmised that the setting is not private enough for college students still young enough to be totally focused on what their peers think of them. But it will be tried again. A stall was erected on campus where information was imparted to the students, condom demonstration was conducted, and condoms were distributed as well as flyers. A presentation was conducted during the orientation program.
- A demand creation event was conducted at Marua Mall which drew record numbers of those unafraid to show interest in HCT. Over 596 males, 570 females visited the stall and got directions to the centre, asked questions related to HCT and to obtain informative flyers. IEC materials were disseminated with directions to the centre and contact details. The following number or materials were distributed:

Mobilization on MCP at Okahao

- The Tonateni New Start centre has made great strides in forging a strong working bond with the MoHSS and conducting on-going outreach testing reaching out to isolated communities. This is a major development and the original plan when outreach first got approved by the MoHSS. The CM has been a driving force and has prepared all of the communities in advance ensuring very high turn outs. The team is adhering to quality guidelines and therefore returning to these sites to test all who want the service. Notably the villages of Oshikondiilongo and Omashekediva have had large crowds wanting HCT and hundreds of tests done and results given.

Third Quarter

FOCUS ON MEN-

This quarter was very busy for New Start community mobilization. However this report will outline the increase in male focused community mobilization events. IntraHealth supported New Start partners were trained in how to reach and communicate with men during the last quarter in order to provide IPC and CM support sessions for the STRONG campaign. They answered and the call:

- Rundu Town Council Technical department where majority of the workers are men. The objective of the activity was to raise awareness on VCT among these men. The meeting was organized in collaboration with the town Engineer who was very welcoming and has agreed to give his men time off to get a test.
- Sauyemwa Roman Catholic Church-After Sunday church services the CM addressed the crowd on male engagement topics. . The topics covered were the benefit of HIV test and the reluctant behavior of men in the fight against HIV. The MCP flannelgram was used as a facilitating tool during this meeting.
- Rundu Mission Church which was the venue for the Catholic Men's Conference. The NS addressed the gathered men on the need for male engagement, male testing and encouraged me to take the lead in the fight against HIV "We are the heads of the family and we should lead this fight".
- In April the Tonateni New Start community mobilizer focused his male engagement activities on the Namibian police. With IntraHealth introductions he has forged strong bonds with the force and therefore was able to reach the higher ranked officers at both Ongwediva and Oshikati police stations reaching 38 including the Police regional commander. The focus remains on creating demand for HCT and creating the links between HCT and longer life through HAART. But he also encouraged the officers to make provisions for their members to go for a test and/or arrange outreach testing events especially to reach the special field force.

Police regional commander Comm. Kashipulwa

- In an effort to streamline community mobilization in Khomas region and also as efficiency measure a Khomas regional community mobilizer has been appointed during this reporting period. This gentleman is young but accomplished and a professional social worker. He will lead all New Start community mobilization efforts in Windhoek and the environs. He will work in close cooperation with all three WHK centers. The first step was to hold a stakeholders meeting to ensure that all understand his mission. This meeting was held between LLCL, CAA, IH and New Start site managers. This initiative is a marked departure from how business was previously conducted, which was all three centers having their won CM who mobilized for that centre. The Khomas CM will mobilize for New Start as a franchise and not individual centers. During the stakeholders meeting the city was carved up into New Start constituencies and maps have been produced to indicate these constituencies. These are specifically for use for outreach testing so that each centre does outreach in a demarcated area.

- The Swakopmund New Start CM focused almost entirely on men with his activities during this reporting period conducting 15 mobilization sessions reaching 974 people. A notable event was an outreach testing event conducted at a new area mine (Areva Uranium). The CM was provided the opportunity to mobilize all the miners and formed collaboration with Namibia Health Plan (NHP). NS and NHP then jointly conducted a health day where 85 miners (all men) were tested for HIV and NHP provided.

- Another successful Community mobilization activity was conducted by the Oshikango VCT community mobilizer 56 people were reached through mobilization in small groups and large groups. The mobilizer observed that most of the attendees were interested to hear the link between HIV and TB.

- The Rundu VCT community mobilizer conducted four community mobilization activities in May. The most successful one took place at The Ministry of Home Affairs which is within Rundu Town. There are always a lot of people at this office getting their national documents [birth certificate, Identity cards and passport]. Following the arrangement with the senior supervisor at the Ministry we had a very successful meeting. The main topic of discussion was the danger of HIV and awareness on MCP (Multiple Concurrent Partners) and Transactional Sex behaviors. About **42** males and **79** females were reached during this mobilization. We

learnt that lots of people spend up to a full day here just queuing up for services and there is a proposal to set up an IEC corner that can be filled on a weekly basis.

Fourth Quarter

- In the Khomas region a total of 1 226 clients were reached by Community Mobilization activities during this quarter. The majority of these were male clients as they were targeted due to low levels of male participation in HCT services. The major highlight among these activities were activities targeting taxi drivers in Windhoek. A meeting was held between the Khomas Regional Community Mobilizer and the two site managers of the VCT sites in Windhoek on targeting taxi drivers so that they can test for HIV. The discussion was based on the point that taxi drivers are neglected and are not targeted thus; there are people who are at high risk of getting HIV. A plan was drawn up on how taxi drivers would be targeted and it was further suggested that one day in every week was to be reserved for taxi drivers to test for HIV and preferences will be given to them only and they will be treated special.

- During this quarter Community mobilization activities in the Oshana Region positively contributed to scaling up outreach testing and counseling services for target groups, especially in men and youth. A total of 2171 people attended Community Mobilization activities conducted by the Community Mobilizer at the **Tonateni New Start Centre** during this quarter.

- A total of 1 966 clients were reached by community mobilization activities at the Lifeline Oshikango New Start Centre during this quarter. The majority of these were men who were actively engaged in male HCT activities. A notable highlight was the taxi/truck driver testing promotion from 14/09/-09/10/2009 and the draw was done through NBC Oshiwambo radio whereby community mobilizer gave numbers to the viewers on air and each caller had to select a number t to stand a chance of winning a prize. Sixteen taxi and twenty-four truck drivers tested throughout that period and out of those drivers, one truck and two taxi drivers tested positive while 14 taxi and 23 truck drivers tested negative. Eight winners from taxi drivers, each receive N$100 petrol voucher and eight from truck drivers, each receive a bag with toiletry for the value of N$100 while drivers from each group who referred many clients for testing during that period, received car seat covers for the value of 150 each.

- A total of 686 clients were reached by Community Mobilization activities at the Lifeline New Start Centre at Rundu. The majority of the clients were male as activities were mainly geared towards engaging male clients, who traditionally showed very low levels of participation in HCT activities. A major highlight at the Rundu Lifeline New Start Centre during this quarter was the Community Mobilization activity conducted at Kalayi Border Post which is situated about 7 km east of Rundu town on the Kavango River. This Namibia /Angola border post divides Rundu town on one side and Kalayi town on the other side. People living on either side of the border share a common language with some has families on both sides of the border. Additionally, the border post is busy as people from either side cross over to buy and sell supplies. Consequently, these people are vulnerable and hence the need for the mobilizer to raise HIV awareness to this target group. Since the people at this post are always on the move, the mobilizer used a strategy of engaging people in a discussion as they were passing by one by one or in a group of two. The mobilizer also had a chance to talk to taxi driver who were transporting people to and from the border post. The following topics were discussed; the danger of HIV and awareness raising on MCP (Multiple Concurrent Partners) and Transactional Sex. About eighteen (**18**) males were reached and twelve (**12**) females during this mobilization.

Transition of HCT Partners

At the outset of the award, IntraHealth entered into direct sub-awards with nine local organizations supported by USAID/Namibia through the President's Emergency Plan for Aids Relief (PEPFAR). Five of these local organizations were stand alone Voluntary Counseling and Testing (VCT) sites. Due to substantial VCT budget cuts for COP10, IntraHealth in consultation with the MoHSS and stakeholders decided to cease funding VCT operations beyond September 30, 2010, in 7 standalone centers namely Katima NRCS, DAPP Outapi, WBMPC, DRC Swakopmund, ELCAP Mariental and Otjiwarongo and CAA BNC. The cost per client and availability of other HCT services in the area were the main considerations informing the decisions. Most of these centers will not be able to continue VCT services without PEPFAR. CAA Tonateni will continue operating under direct funding from USAID. In all locations, clients will be redirected to alternative Government Republic of Namibia (GRN) sites in the vicinity to access HCT services.

IntraHealth is following a strict close-out regimen for these partners guided by internal policy. All partners whose agreements are allowed to expire and cannot acquire additional sources of funding to continue operations will need to make provisions for the disbursement of equipment, notification and release of staff according to Namibia labor laws, and the security of medical records. IntraHealth engaged with the partners and actively assisted them through this close-out process

Challenges, Constraints & Plans to Overcome Them

- *Budgets cuts:* The HCT is faced with a budget cut of more than US$1.7 million for FY2011. This substantial budget cut resulted in IntraHealth ceasing funding to more than half of the HCT standalone sites in FY2011. Most partners are not be able to continue providing HCT services without this funding and thus will close. This move resulted in job losses and loss of qualified and competent staff in which a lot has been invested including training. Access the HCT services in these areas will not be severely compromised as clients should be able to access the nearby MoHSS HCT centers and other New Start centers.

- *Closure of the North West IntraHealth Regional Office:* The North West office was closed following the VCT budget cut for FY2011 and also the resignation of the Regional VCT Coordinator in June 2010. HCT QA will continue to be provided from the IntraHealth Windhoek office.

- *Training***:** The agency identified and approved to provide all HCT trainings in the country has a lot of competency issues which were picked up in the last training they conducted for IntraHealth partner staff. This development implies that IntraHealth will not utilize their services for further trainings. IntraHealth will continue to engage the MoHSS to identify alternative training agents.

- *Male Involvement:* Males still lag behind in terms of HIV testing service utilization, despite the "Strong Man" campaign in which IntraHealth's collaborated with the MOHSS and the organizing partner Nawa Life, in order to reach out to men and encourage male uptake of testing services. Recent data collected and reported shows that females still outnumbered males in utilizing HCT services though a general increase in clients coming to access HCT was noted in the last two quarters of FY2010.

- *Referral System:* The current referral system has not been effective in tracking clients tested in New Start centers referred for other services such as care and treatment and other community based support services. IntraHealth has been working with the MOHSS and its stakeholders to develop an effective referral system. A draft document has now been developed which still needs to be finalized and approved.

- *Cessation of funding for the New Start centers:* The news of the funding cessation has compromised the number of clients seen at the centers as the staff members were demoralized and consequently some New Start centers failed to reach their set targets for the COP, despite IntraHealth surpassing the annual set target of 72,000.

Planned Events for the Next Quarter

- Continue outreach counseling and testing activities with remaining HCT partners
- Continue QA visits and mentoring to all sites
- Continue male only testing days in some sites such as CCN.
- Continue building capacities of grantees to conduct supportive supervision.
- Roll out safety net program through staff training with MoHSS.
- Integrate Family Planning Counseling and referral into HCT services.
- Revise the HCT supervision tool to incorporate the PI approach.

2.6 Program Area 6: *TB/HIV (HVTB)*

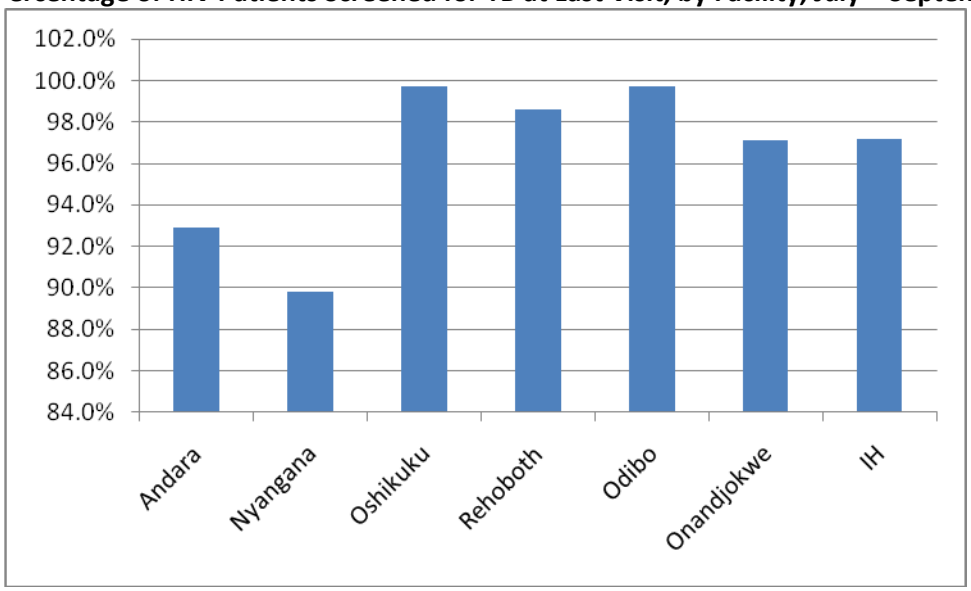
During the reporting period, IntraHealth has continued its support to the TB/HIV collaborative activities. These activities are aimed at strengthening linkages between the TB clinics managed under MoHSS at IntraHealth-supported sites. Currently, 28 outlets are supported by IntraHealth to provide TB/HIV integrated services.

Accomplishments & Successes

In order to decrease the burden of TB among PLHIV, all sites are engaged in the implementation of the WHO-recommended three I's: intensive case finding; infection control; and, INH prophylaxis. To decrease the burden of HIV in TB patients, a successful collaboration and referral system between TB clinics and HIV services facilitates the routine offer of HIV counseling and testing (CT) to all TB patients presenting with unknown HIV status. Similarly, patients accessing services from other hospital departments, both IPD and OPD, are evaluated for TB when/if they are symptomatic and offered HIV CT using the provider-initiated testing and counseling (PITC) approach.

At the end of the fourth quarter, 387 (79%) of the 487 TB clients registered were tested for HIV and received their test results in the supported sites. Of the 1,873 TB clients registered in FY2010, 1520 (81%) were tested for HIV and received their test results in the support sites. Of those who had TB and were tested for HIV, 240 (62%) tested HIV+ in the fourth quarter, and 877 (58%) during all of FY2010. The prevalence of HIV among TB patients has remained between 50-60% in most sites, indicating that the TB/HIV co-infection is still a crippling dual burden. All TB patients testing HIV+ were transferred for enrollment in HIV care and for clinical and laboratory evaluation, according to national eligibility guidelines. All sites have been synchronizing clinic visits for those co-treated to receive their follow-up care on the same day and reduce additional visits for each condition.

Figure 3: Percentage of HIV Patients Screened for TB at Last Visit, by Facility, July – September 2010



By the end of the reporting period, 16,334 (97%) of 16,802 patients enrolled in HIV care and visited the facility during the reporting period were actively screened for TB at their last visit. *Figure 3* (see above) shows the percentage of HIV+ patients screened for TB during the fourth quarter of FY2010, by facility. Nearly all, 4 of 6, main supported sites are screening 97% or more of their HIV+ clients for TB during the last visit, with the exception of Nyangana and Andara, which screened approximately 90% and 93% of HIV+ patients respectively. Nyangana has improved slightly from 88% during the previous quarter. This improvement, though slight could be attributed to the performance improvement approach (PIA) implemented by IntraHealth. A total of 127 patients enrolled in care were initiated on TB treatment during the quarter and a total of 404 PLHIV enrolled in care were initiated on TB treatment during FY2010. During the fourth quarter, 682 PLHIV were initiated IPT, making a total of 2,173 initiated IPT during FY2010, at the main IntraHealth-supported sites.

Other Accomplishments:

- District meetings were conducted at least quarterly where TB/HIV collaborative activities are discussed.
- Rehoboth conducts multidisciplinary TB/HIV ward rounds with the medical officer, district HIV coordinator, district TB coordinator, counselors, and social worker on a weekly basis thus offering a platform to coordinate care of TB/HIV patients as well as addressing programmatic challenges
- TB infection control efforts continued in all facilities with environmental and administrative measures put in place in Andara and Nyangana which include using the open verandah as a patient waiting area and triaging of coughing patients and teaching patients on cough etiquette.
- Quarterly support visits conducted by IH to all sites
- Participated in the MoHSS joint support visits in August/ September.
- The number of patients initiated on IPT has improved tremendously in Oshikuku and Nyangana from 1 and 74 in the last quarter to 107 and 118 respectively, during the fourth quarter. These improvements are due to the PIA and task shifting of screening and prescribing INH to Registered Nurses as well as support and supervision by IntraHealth. In addition, Oshikuku is now providing INH in the ART clinic.

Challenges, Constraints & Plans to Overcome Them

- While the TB screening for patients enrolled in HIV care has greatly improved in all the facilities, in Odibo the number of patients recorded to have received IPT is very low. This may be a data capturing issue and IH will work with the AMS team using the PI approach to identify the root cause and develop appropriate interventions.

Planned Events for the Next Quarter

- Conduct supportive supervisory visit to partner facilities and provide additional technical assistance, as needed.
- Continue intensifying PIA in all the centers particularly Andara, Odibo and Nyangana.

2.7 Program Area 7: *Care – Adults*

Under IR4, pursuing the goal of reducing morbidity and mortality among PLHIV, IntraHealth is supporting the implementation of the facility-based clinical component of the minimum package of basic health care in 6 faith-based health facilities and their satellites. In the fourth quarter of FY2010, 28 service outlets were providing the integrated palliative care package.

The following elements of the clinical care are provided: prevention and treatment of OIs, including cotrimoxazole prophylaxis for eligible HIV-positive patients; TB screening; Isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support (including spiritual counseling) and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Adolescent and Adult illness (IMAI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

The main activities of this program area include enrollment of patients for chronic care and eligibility for ART through clinical, immunological and social evaluation, and adherence counseling. The program further screens for opportunistic infections and provides prophylaxis. Patients are also provided with psychosocial support and linked with other palliative care providers, such as the Red Cross and other community-based organizations.

During the fourth quarter, a total of 21,319 adults were actively provided with at least one clinical care services, and 23,964 during the whole of FY2010 . The program has exceeded the FY2010 target for this program area by 31%.

Of those patients receiving palliative care, 14,011 adults are currently receiving ART. The remaining number includes those on pre-ART care until they qualify for ART initiation, as well as patients who are lost to follow up, transferred out, or stopped receiving ART but are still receiving care. Patients in pre-ART care are actively followed up and provided with the above-mentioned package of care. In higher volume facilities, pre-ART care has been strengthened through assignment of specific nurses to the duty of registration and follow-up of these patients. This will improve the timely initiation of ART in an effective continuum of care, as CD4 count and clinical monitoring are critical to optimum timing of treatment initiation. By the end of FY2010, 14,683 adult patients received cotrimoxazole prophylaxis (CTP).

During this reporting period, 743 individuals received spiritual counseling (712 from Oshikuku hospital, 1 from Nyangana and 30 from Onandjokwe, bringing the total to 1,132 since the inception of the spiritual counseling program. In Oshikuku, there is dedicated nurse responsible for spiritual counseling coordination which has led to these tremendous results.

IntraHealth will continue to support PIA efforts through training and follow-up on sites on identified gaps. The support supervisory visits were conducted. Of the 4 planned visits, 3 were conducted.

Challenges, Constraints & Plans to Overcome Them

Three IH supported sites are not providing spiritual counseling in spite of trained chaplains from all sites. In Odibo, one trained chaplain relocated and the only one remaining is overstretched and does not have time for spiritual counseling. IH will continue to train additional chaplains to meet spiritual counseling demand, especially in the three facilities not performing spiritual counseling activities.

Planned Events for the Next Quarter

- Continue supportive supervision visits to partner sites.
- Continue scaling up access to spiritual counseling in all IntraHealth supported sites.
- Training of chaplains in the next quarter.
- Training of nurses and counselors in spiritual counseling.

2.8 Program Area 8: *Treatment: ARV Services – Adults*

Under IR 4, IntraHealth is supporting an integrated and comprehensive HIV and AIDS care and treatment program for adults in six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth supported 28 outlets in the provision of HIV and AIDS clinical care.

Accomplishments & Successes

Overall, 14,011 adults living with HIV are currently receiving antiretroviral therapy (ART). During the reporting period, 830 (a total of 933 adults and children) HIV positive adults have been newly initiated on ART, and a total of 3,013 in all of FY2010 (*Figure 5*). When the pediatric patients are included, a total of 3,401 patients were initiated on ART, representing 103% of the FY2010 target of 3,300 new patients. Out of 20,725 adults ever starting ARV since the beginning of the program, about 70% are still receiving the treatment by the end of September 2010 (not excluding those transferred out). This relatively good trend of retention is a result of significant and continued efforts in adherence counseling, support group activities and active defaulter tracing. *Figure 4* (see below) shows retention in ART at 12 months after initiating treatment for the October 2008 to September 2009 cohort. More efforts need to be directed to Andara hospital which is achieved a retention of less than 70% at 12 months.

Figure 4: Retention in Care of ART Patients at 12 months of initiating ART, by Health Facility (October 2008 - September 2009 Cohort)

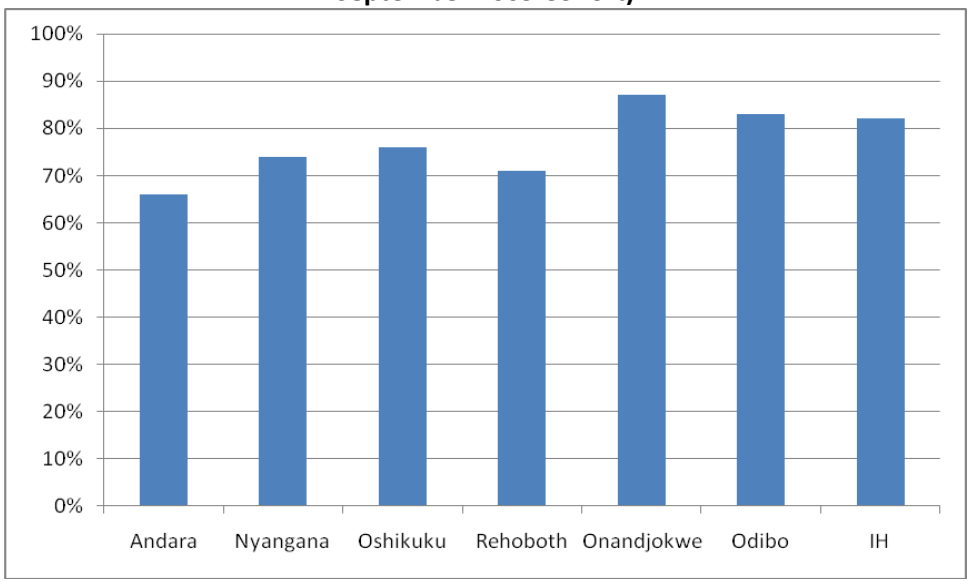
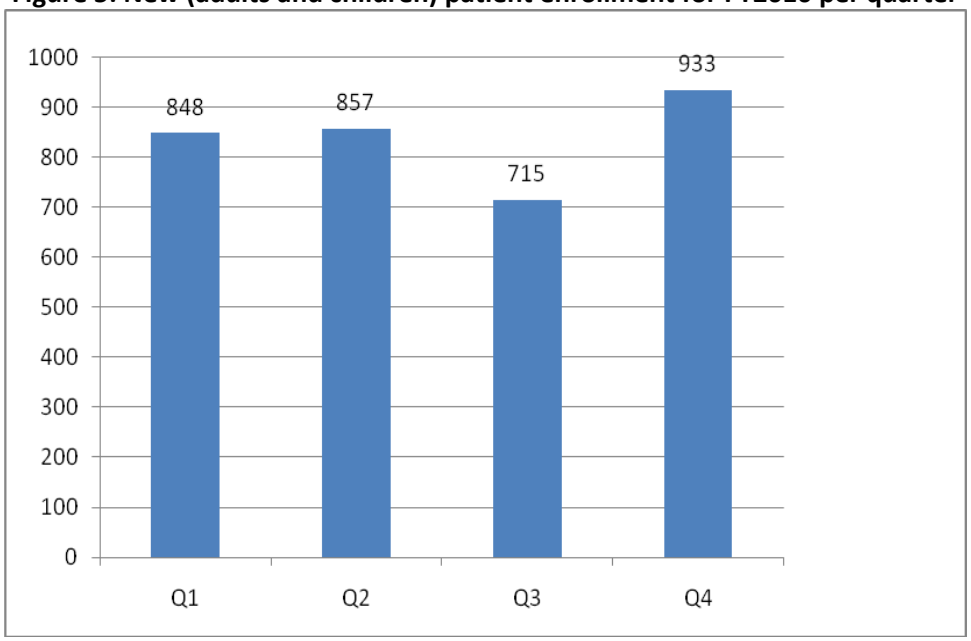


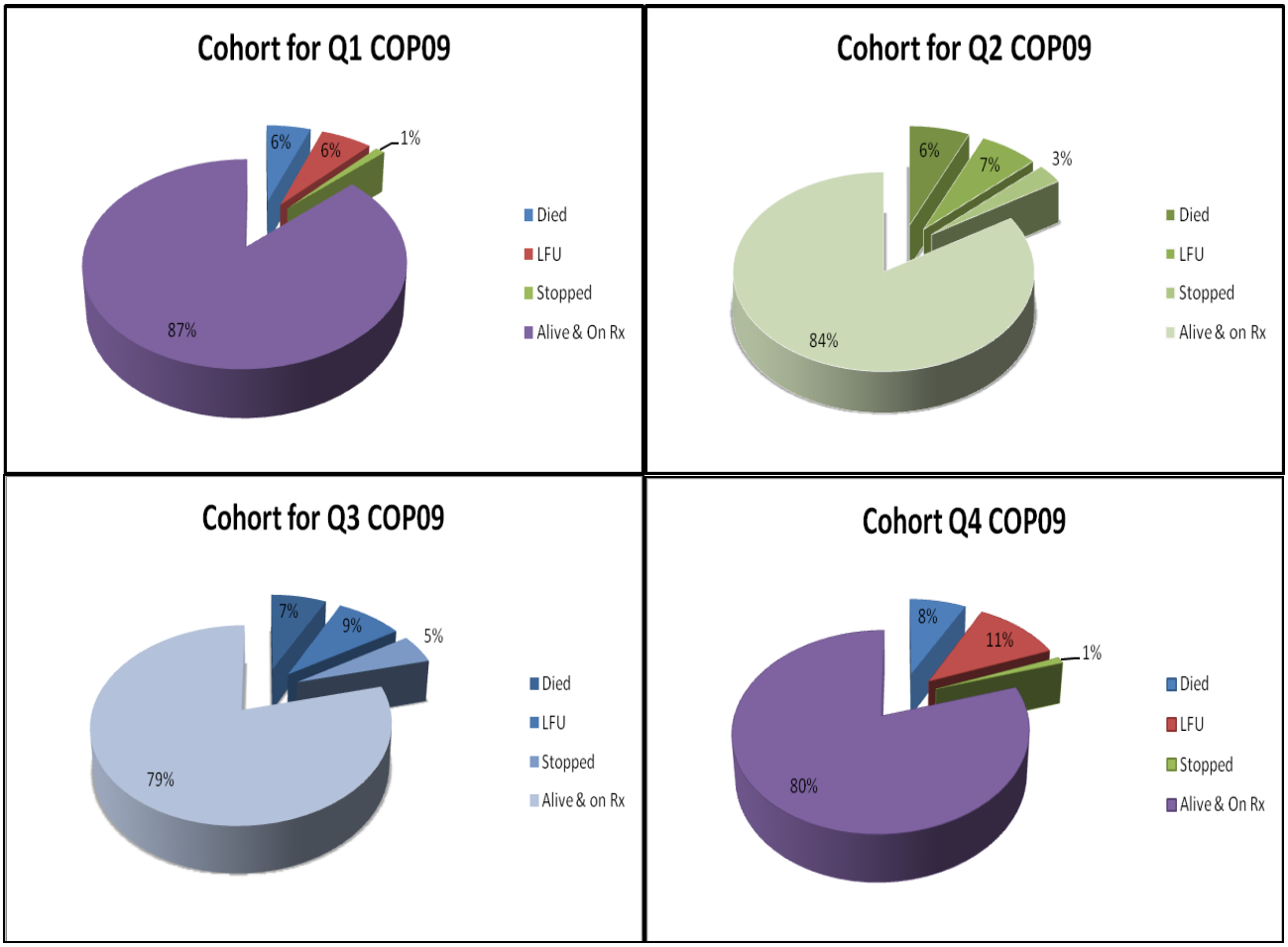
Figure 5: New (adults and children) patient enrollment for FY2010 per quarter



WHO Early Warning Indicators *(Optional Indicators)*

The lost to follow up in IntraHealth-supported sites may be due, in part, to the location of these facilities in rural and semi-rural areas in which the population faces challenges including distance, poverty, unavailability of transport in some directions, food insecurity and the flood situation in the North. These challenges will be addressed by strengthening outreach activities, which may require additional resources, such as vehicles and staff. Figure 6 (see below) shows retention in care, mortality, lost to follow-up and patients who stopped ART, for all patients according to one cohort in each quarter of FY2010.

Figure 6: Patient outcomes at 12 months by quarterly cohorts (Patients initiated treatment from October 2008-September 2009)



Additional Highlights

- The construction of Omuthiya Hospital is in progress by the MoHSS. Already, all patients from this area are being taken over by this hospital, which has helped to alleviate the existing patient load at Shanamutango (LMS, Onandjokwe).
- The monthly ART outreach, which begun in the second quarter at Odibo Health Centre to Omunama village (situated at 30 kms from the facility), is going on well and currently 556 (pre-ART and ART) patients are being served of which 80 are children.
- LMS management had funded the construction of a new ART pharmacy to address the space challenge faced by the Shanamutango. The pharmacy is at the last phase of the construction and will be completed by end of the next quarter.

Challenges, Constraints & Plans to Overcome Them

- The number of patients receiving services at ART clinics has outstripped the available space in most of the facilities. Partners are being encouraged to source alternative funding for expanding their existing infrastructure. Increase in the outreach activities is also expected to decongest the main facilities.
- All IntraHealth supported sites are conducting tracing of ART patient defaulters; however, the availability and cost of transportation remain major challenges, especially in Onandjokwe.
- The revised ART national guidelines were launched in September 2010. Hence the SOPs were not developed as we were waiting for the update ART national guidelines

Planned Events for the Next Quarter

- Continue supportive supervisory visits.
- Continue to strengthen ART outreach activities, especially in Onandjokwe.
- Develop treatment SOPs in the nextFY2011

2.9 Program Area 9: *Care – Children*

Under IR4, pursuing the goal of reducing morbidity and mortality among PLHIV, IntraHealth is providing support to the provision of HIV care to children infected, or suspected to be infected, with HIV. The following elements of the clinical care are provided: prevention and treatment of OIs, including cotrimoxazole prophylaxis for HIV-exposed infants, TB screening; isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support (including spiritual counseling) and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Childhood illness (IMCI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

As a result of the wide use of DNA PCR testing for HIV exposed infants, more infants and young children are enrolled in care. By the end of this reporting period, 3523 children under the age of 15 had been provided with HIV clinical care. This represents 13% of the 27,487 individuals currently receiving care, including adults.

In all IntraHealth supported sites, pediatric care also includes the diagnosis and treatment of malaria, and referral for routine and timely immunization programs and campaigns. Routine provision of CTX at 6 weeks of age is given, according to the national guidelines for HIV exposed infants. For HIV+ children, CTX is continued, as well as IPT, TB screening, nutritional assessment, and pain management. All IntraHealth supported facilities offer diagnosis and management for OIs and co-morbidities, including diarrhea and pneumonia. As with adults, all children in care are screened routinely for TB in every follow up visit, and referrals are made for suspected cases to the TB clinic for registration, prescription and follow up. Likewise, HIV testing is conducted for all children diagnosed with TB. Infants initially testing HIV- but remaining at risk due to ongoing exposure from breastfeeding are also retested.

Additional Highlights

- IntraHealth supported facilities continue to offer close follow up and adherence counseling are provided for children. These sites utilize the ePMS for defaulter tracing, i.e. patients lost to follow up, and also provide spiritual care and referral to other services provided be the GRN, other NGOs and FBOs.
- Nutritional assessment, counseling and support, including infant feeding counseling in the PMTCT and pediatric care programs, based on AFASS, also continue to be provided. In addition, anthropometric status is monitored, micronutrient supplementation (multivitamin, Vitamin A, iron and folic acid) is provided, and severely malnourished children are referred for admission to the inpatient ward.
- IntraHealth is supporting its partners to provide family centered pediatric and adult HIV prevention, care and treatment programs, in which children and their families are given co-scheduled appointments to ensure adherence, reduce stigma and minimize transport costs. As part of this family-centered approach, partners encourage counseling and testing of children from previous pregnancies for all mothers enrolled in the PMTCT program.
- Onandjokwe is providing a child friendly setting, in which a specific room is used to receive children; the room is decorated for children, and toys are available for them to play with during the visit. An average of 1,050children attended each month during the reporting period.
- Onandjokwe has also established an adolescent friendly room in order to comprehensibly and systematically address the issues of adolescents living with HIV/AIDS, including psycho-social and sexual health issues.
- Kitchen corner activities are intended to be conducted weekly in Oshikuku and Onandjokwe districts. The package includes education on a balanced diet, as well as practical demonstration of food preparation using locally available foods. Oshikuku also encourages mothers to grow foods in home gardens. Participants include caretakers of all children under 5, pregnant and lactating women irrespective of HIV status, HIV infected children, adolescents and adults. Weekly events are conducted by 1 nurse and 1 community counselor, both trained on nutritional issues. The children who attend the event range from 4 months to 14 years, regardless of nutritional status in order to avoid stigmatization.
- A total of 63 PMTCT mothers attended nutrition classes during the four quarter and 211 for the four quarters of FY2010 in Oshikuku, which specifically targets mothers in the PMTCT program.
- Oshikuku hospital started nutrition classes to caregivers of HIV+ malnourished children during the last quarter without demonstration. Moving from mothers alone to children shows a great achievement.
- Onandjokwe focuses on caregivers of HIV+ malnourished children. During quarter four alone, 187 children and their caregivers attended the nutrition sessions. A total of 333 children with their caregivers were reached during FY2010, and an additional 10 mothers referred from the wards.
- Onandjokwe also had planned to start kitchen corner activities for PMTCT mothers.
- Nyangana hospital also had planned to start kitchen corner activities in the next quarter.

Challenges, Constraints & Plans to Overcome Them

- Clinical staff responsible for the adolescents' friendly room in Onandjokwe are still not specifically trained to work with adolescents. Training will be needed for an effective adolescent program.
- Kitchen corner activities not yet started in all IH supported sites, mainly due to shortage of staff.

Planned Events for Next Quarter

- Strengthen Kitchen Corner activities in Onandjokwe.
- Support the training of responsible nurses for adolescents' friendly room in Onandjokwe.
- Continue supportive supervision visits to partner sites.
- Support Nyangana hospital to start kitchen corner activities in the next quarter.
- Support all IH supported sites to initiate kitchen corner activities in the second quarter.

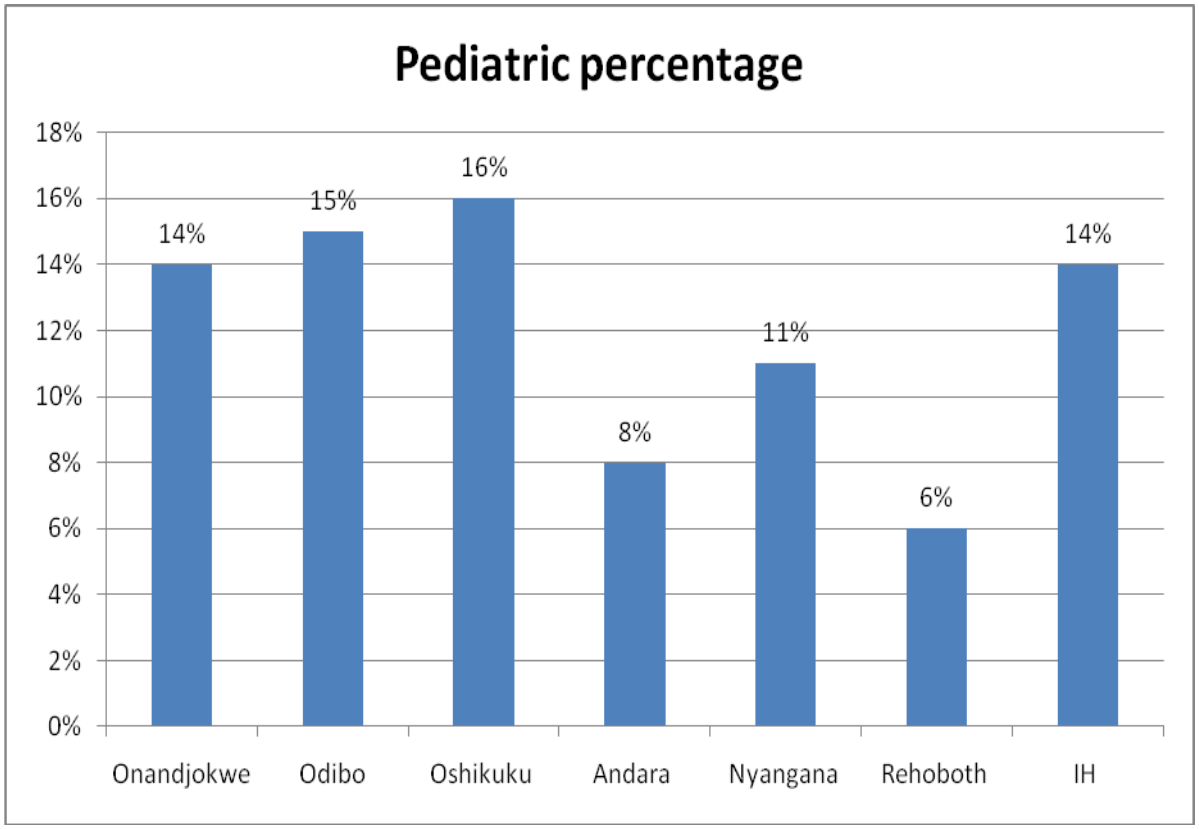
2.10 Program Area 10: Treatment: *ARV Services – Children*

Under IR 4, IntraHealth is supporting an integrated and comprehensive HIV and AIDS care and treatment program for children in six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth supported 28 outlets in the provision of HIV and AIDS clinical care and ARV services for children.

Accomplishments & Successes

Overall, 2,286 (14%) children on HIV care are currently receiving antiretroviral therapy. In the fourth quarter of FY2010, IntraHealth supported sites enrolled 103 children (11% of new patients) onto ART and 322 children through all four quarters of FY2010. *Figure 7* (see below) illustrates the percentage of children, out of the total number of patients on ART, by facility at the end of the reporting period. Partner facilities have been continually sensitized to active screening and earlier identification and recruitment of HIV-exposed children in order to expedite entry into care and treatment. Early infant diagnosis and the recommended WHO approach of commencing ART earlier for children have been rolled out in all IntraHealth supported sites. This change in treatment protocol is expected to have a significant increase in the ART initiation among children younger than 24 months of age.

Figure 7: Percentage of Children on ART to Total ART Clients, by Health Facility, October 2009 - September 2010



Additional Highlights

- Odibo and Onandjokwe hospitals have managed to liaise with PHC department to trace defaulters, including adults.

Challenges, Constraints & Plans to Overcome Them

- Infant tracing for has proven to be difficult due to staff shortages and limited connectedness (i.e. no cell phone, etc.) of mothers.
- Shortage of staff and transportation continues to handicap outreach and defaulter tracing, especially in Oshikuku and Onandjokwe.

Planned Events for the Next Quarter

- Continue to strengthen ART outreach activities
- Continue support supervisory visit
- Strengthen defaulter tracing in all IntraHealth supported sites.
- IH will encourage Onandjokwe hospital and all satellite facilities to liaise with the PHC department to trace all exposed infants.

2.11 Program Area 11: *Health Systems Strengthening (HSS)*

Since June 2006, the IntraHealth has been working to strengthen the organizational capacity of indigenous Namibian organizations to deliver effective and efficient HIV/AIDS prevention, care and treatment programs. In addition to providing clinical and programmatic oversight, technical assistance and support, an important strategy has been to undertake a capacity building process among the partner organizations to prepare some of them to eventually move to direct USAID funding (graduation) and for others, to improve their organizational sustainability. Capacity building efforts to date have emphasized operational support (grants management, financial management, reporting and logistics, policies and procedures) and key institutional strengthening dimensions (strategic planning, leadership and management, human resource management, and monitoring and evaluation).

IntraHealth underwent a staffing realignment in the fourth quarter of FY2010 due to the departure of the Senior Program Manager in charge of local partner capacity building. This staff restructuring, in which the HRIS Technical Advisor assumed responsibility for all Health Systems Strengthening activities with increased support from the IntraHealth Finance department and Chapel Hill, resulted in no lost time and progress continued in this program area. The cessation of funding to the less cost efficient stand alone HCT partners has allowed IntraHealth to focus its local partner capacity development activities on its four remaining, and largest, partners – AMS, CHS, LMS, and LL/CL. Looking ahead to year three of the agreement, IntraHealth remains on target with its thorough capacity development plan that will enable the partner organizations to create the management systems necessary for graduation to direct USAID funding.

Accomplishments & Successes

Local Partner Capacity Building

IntraHealth organized a training on USG rules and regulations for local partners and staff, conducted by Inside NGO. This activity, which took place from June 28-30, was a key opportunity to build the capacity of staff in the area for grant management, with emphasis on USAID rules and regulations. In all, 17 participants from partner organizations attended, including 3 from AMS, 2 from CAA, 4 from CHS, 3 from LLCL and 5 from LMS, as well as 10 participants from IntraHealth.

The consultant recruited in March completed the task of assisting LL/CL to address the DCAA recommendations. USAID performed a pre-award assessment for LL/CL in August 2010. The assessment included the review on whether recommendations provided by the DCAA had been implemented. Based on feedback from this assessment, the conclusion is that LL/CL has acceptable policies, procedures, financial management and internal controls adequately to manage and account for USG funding.

The consultant has shifted focus to CHS, and has started the process of addressing the DCAA recommendations. The work plan has been revised to guide the process with 2 phases being identified to complete the work. During the first phase, policies and procedures will be updated, revised and aligned with the USAID rules and regulations. The second phase will focus on implementing these policies and procedures and making the necessary organizational and systems changes to support the implementation. The IntraHealth management team will continue to work closely with the consultant to ensure activities are successful in strengthening partner capacity and moving these organizations in the direction of graduation.

As of October 1, 2010, AMS became an official subpartner of IntraHealth. IntraHealth supported AMS in preparing a budget and scope of work. In addition, the project has provided technical support in systems strengthening that included training of staff in VIP payroll processing, accounting for program transactions using the Pastel accounting system, as well as the preparation and submission of monthly financial reports and quarterly financial and program reports. All staff, which were initially IntraHealth staff, elected to remain with AMS following the transition.

Photo: Role playing personality types.

IntraHealth conducted a third training in Supervision and Personal Development for WBMPC board, management and staff. The aim of the training, attended by 15 people, was to create self-awareness, assist supervisors to improve their supervision skills, and improve supervisor-supervisee relationship.

IntraHealth continued to provide assistance to its sub-partners in the form of site visits mainly to ensure that financial management systems are operating at an acceptable level and to ensure compliance with USAID rules and regulations. Review reports were prepared and provided to the relevant sub-partner after each visit. The reports included recommendations for improvement and follow-up visits are performed to ensure full implementation of the recommendations and resolution of the identified weaknesses.

IntraHealth provided guidance as part of the transition plan to the seven VCT sites that are earmarked for closure between October and November 2010. The guidance included the accounting for program assets and materials, retention of records and accounting for stocks of RT materials. Liaison is still continuing with these partners to have signage that directs clients to alternative sites for VCT services. In addition, IntraHealth is working with these partners for possibility of them accessing alternative funding for continuation of services and the technical assistance that IntraHealth can provide.

Finally, IntraHealth provided technical support to MOHSS in order to help revive the Nursing Association. IntraHealth facilitated a two day consultative meeting, June 9-10, 2010. The meeting sought, in part, to address the public outcry over poor nursing care. The participants concluded that the revival of the Nursing Association may assist nurses with professional growth, career development, international information and exposure to new information and technologies.

Human Resources for Health/ Human Resources Information System

The first three regions were connected to the HRIMS in 2009 with the connection to the HRIMS being concluded in February 2010 to a further 6 regions, Karas, Omaheke, Otjozondjupa, Oshana, Omusati and Kavango. IntraHealth has completed 89% of the activities to roll out the human resources information system (HRIS) for the MoHSS in the remaining 4 regions namely Kunene, Ohangwena, Oshikoto and Caprivi. Upon completion of these 4 regions, which is earmarked for end of October 2010, we will have a success rate of 100% of MoHSS Regional Management offices that have been provided with an online connection to HRIMS, email and internet services to date. The HRIMS provides human resources and health care managers with timely, accurate and complete data for decision making. Specifically, the system tracks health care workers from the time they enter the MoHSS until they leave the workforce, including capturing data on training, certification, professional licensing renewal and reasons for attrition.

The Namibian MoHSS conducted an extensive Health System Review and compiled a 5-year strategic plan, 2009-2013, based on this review. IntraHealth will continue to support the MoHSS requirements as detailed above, and will continue to offer technical support aimed at reaching the strategic objective of having a functioning integrated management information systems in place by 2013, as defined in the MOHSS 5-year strategic plan. Further activities will be considered for support as requested by the MoHSS and the Stakeholder Leadership Group.

IntraHealth's strategy is to build the required HR and IT infrastructural capacity to sustain and support the MoHSS in achieving its NDP3 and the Namibian government's vision 2030. For the period under review, the key accomplishments in this strategy were, more specifically:

- Formally concluded the HRIMS Rollout to 6 Regions Project and started the HRIMS Rollout to 4 Regions Projects, which entails rolling out the HRIMS to Kunene, Ohangwena, Oshikoto and Caprivi regions by end of October 2010. HRIMS is already live in these 4 regions from August 2010 and the regions now have access to internet and e-mail facilities. In total 44 health workers have been equipped with computers, terminals and network printers.

- Continued with data assessments to ensure at least 2.5% of the HRIMS data were assessed for completeness and accuracy; this is an essential exercise to be continued after HRIMS is live in order to ensure the data is accurate and complete and can be used as a basis for management decisions.

Challenges, Constraints & Plans to Overcome Them

Local Partner Capacity Building

- One of the challenges encountered during the visits to partner organizations during the year was their uncertainty regarding funding beyond the current project period – some partner organizations are worried that funding will not continue. Consequently, they are reluctant to undertake major organizational reform and change. CHS has embraced the opportunity, as the organization recognizes this as an opportunity to strengthen systems.

Human Resources for Health/HRIS

- A key risk to the success of the HRIS Program remains the MoHSS IT staffing. The current level and capacity of the MOHSS IT staff are inadequate and although 2 of the previously 4 vacancies have now been filled, we are still experiencing delays in IT support. This matter has been brought under the MoHSS Management attention with recommendations to address, and IntraHealth is still expecting formal feedback in this regard. Recommendations made are that the education requirements for the regional administrators should be changed from a 4-year degree to a 3-year diploma with appropriate work experience. As an interim work-around, one of the 3 system administrators at national level will be transferred to Oshana region to alleviate the IT support challenges the ministry is facing in the northern regions namely Kunene, Omusati, Oshana, Ohangwena, Oshikoto, Kavango and Caprivi.
- The future of HRIMS and the unavailability of a timeline for HCMS. Through the SLG, IntraHealth hopes to join the project team for the implementation of the HCMS to ensure the interests of the MoHSS are protected and that the benefits to the MoHSS through the automation of their HR processes is maintained.
- As the HRIMS is increasingly being used within the MoHSS for decision making, some reports need to be changed and additional reports have been identified as critically important to HR practitioners in order to optimize the benefits from the HRIMS. Due to the HCMS, OPM is not keen on making changes to the HRIMS and also does not have sufficient resources to assist MoHSS in making these changes.
    - OPM have now agreed to give MoHSS a license to use Crystal Report, reporting software that will allow MoHSS to generate their own reports. However, MoHSS staff will need to be trained to use the software – this software requires some knowledge of databases, a skill that might not be available amongst the current project team members.
- HRIS sustainability is dependent on a few key MoHSS people. The recommendation to manage this risk includes a formal succession plan for the HRIS program within MoHSS and will be presented at the MoHSS Management Committee in quarter 4.

Planned Events for the Next Quarter

Local Partner Capacity Building

- CHS will continue to be the focus for organizational development activities, and IntraHealth will continue to work with the consultant to strengthen the systems and develop and/or revise policies and procedures in order to meet the DCAA audit requirements; a key board meeting is planned for November at which progress will be shared with the Board.
- IntraHealth will continue to provide technical support and capacity building to staff at local partner organizations, especially in the area of financial and grant management; note: activities targeted at strengthening the capacity of local partner staff in technical areas in HIV prevention, care and treatment are discussed above under the relevant programmatic area.

Human Resources for Health/HRIS

- With the HR data for the public sector 100% computerized now, IntraHealth will now focus on assisting the MOHSS in optimizing the HRIMS and using the data to drive management decisions. In order to do this, we need to find a solution for the MOHSS to extract data from the HRIMS and write their own reports. Only OPM can add new reports to the HRIMS currently (which takes very long at this stage) and some of the

current reports do not provide all the information required, so a lot of manual data consolidation has to take place in order to provide data aggregated by region.

- IntraHealth will continue providing technical assistance to the FBO's to automate their HR data and standardize on job titles to ensure we are able to consolidate HR data at a National level.
- IntraHealth will continue to provide technical guidance and support to the MOHSS to get access to the health worker data in the private sector to support a national HRIS.

3. FINANCIAL REPORT (REQUIRED)

Please see the accompanying Excel spreadsheet and complete worksheet "INTRAHEALTH FY10 Q4 15Oct2010.xls".

4. WRAP AROUNDS FOR FY2010

5. ENVIRONMENTAL ISSUES

During FY2010, in compliance with USAID environmental requirements and regulations as per the 22 CFR 216 integrated into ADS 204.5, IntraHealth and the Capacity project-supported sites conducted the following activities:

- The cleanliness and hygiene in all centers have continued to receive emphasis with sites where soup kitchens are provided. Sites are being made aware of the necessity of hand washing for both those who are cooking and for clients receiving the soup.
- Patients are continually provided with information on how to safely dispose items, and recycle bins have been maintained.
- Safety measures are also observed while transporting waste generated from outreach services.

Prevention of TB and especially the multi-drug resistance TB has continued to receive attention. Patients on treatment for MDR are encouraged to receive ART from the ward. Also, counseling sessions for these patients are conducted in the wards. There is limited availability of N95 masks for health care workers, and acceptability of wearing of surgical masks by the patients is very low.

6. Strategic Information & Issues with Data Quality

Strategic Information

During the fourth quarter and throughout FY2010, IntraHealth provided support for the national RM&E subdivision and partners to improve the quality of data, data collection, data use and report writing. The goal is to effectively and efficiently monitor and evaluate the response of IntraHealth and its partners for informed decision making. This will strengthen the capacity of IntraHealth and its partners to collect and use program data and measure its achievements and provide for accountability to the donor. IntraHealth also supported its partners in the use of information for effective program management. This was done through improving and harmonizing data collection tools, ensuring data coordination, data mining, analysis, dissemination and informing evidence-based program planning and improvement.

Accomplishments & Successes

The focus of the program in FY2010 has been on developing the programmatic groundwork and reporting tools for an efficient, effective and fully functional M&E system that aligns closely with the objectives of the Associate Award. Thus, the emphasis has been on developing data collection and reporting tools as well as capacity building of staff at all levels at the partner organizations.

During FY2010 IntraHealth has provided support to the MoHSS, the DSP during the implementation of the 2010 HIV Sentinel Surveillance. This included participating in the drafting of the National Multisectoral M&E plan for the National Strategic Plan and compilation of the National Estimates report. At a regional level, coordination efforts have been strengthened through the involvement of partner organizations in the Regional AIDS Coordinating Committees and strengthening the collaboration of the M&E officers with Regional Councils. In particular, at the district level there has been data sharing for the System for Program Monitoring (SPM).

Major accomplishments of FY2010 include:

- Provided technical support to the compilation of Sexual Behavioral Change baseline reports led by the IntraHealth prevention team, CHS and LL/CL. This includes trainings, data collection, analysis and report writing.
- Provided support and guidance to all partners for collection, analysis and reporting of data in conjunction with Strong Campaign.
- Conducted a basic M&E training for IntraHealth partners.
- Successfully conducted an assessment of data quality and verification to validate data sources and provide back-stopping advice to staff at all 18 IntraHealth supported sites. Feedback is given to the partner after each visit and full reports will be shared during the partners feedback meeting.
- With support from the Monitoring and Evaluation Officer for CHS, IntraHealth completed the data quality check and verification in Katima Mulilo, Andara, Nyangana and Rundu and provided on-site outcome feedback.
- Conducted an ART electronic patient management system (ePMS) TOT training in early June 2010 with MoHSS-RM&E staff. This was done prior to the regional and district staff training scheduled in mid-June 2010. In addition, IntraHealth collaborated with the MoHSS to make improvements to the ePMS.
- Regarding the HCT system, IntraHealth updated the database (Filemaker) software accordingly and strengthened capacity on the use and application of the updated software through onsite training during site visits. IntraHealth also conducted a VCT Filemaker training on the improved version for NW sites in June 2010.
- In collaboration with MoHSS and other partners, supported the establishment of the Namibia M&E Association and participated in developing the draft constitution and strategic plan for this association.
- Supported the development of the National Multi-Sectoral M&E Plan for 2011-2015 and systems through on-going support to the harmonization of the national list of indicators, integration of sub-systems into the national system and building the national capacity in M&E as a key strategy to ensure the proper implementation and sustainability of all strategic information efforts.
- Provided technical assistance for RM&E activities to the coordinating body for the HIV M&E System.

- Played an active role on the Monitoring & Evaluation Technical Working Group (TWG), as well as on the Research and Surveillance TWG.
- Provided technical support to partner organizations, as requested, throughout the period.

Challenges, Constraints & Plans to Overcome Them

- Program managers at partner organizations are overloaded with other day-to-day responsibilities and can only allocate limited time to M&E activities.
- Reporting by field offices needs additional support from their host national office M&E staff for partner organizations. This will improve the quality of data collected and will enhance ownership, involvement and commitment.
- Reporting for the PMTCT program is also challenging as the registers and forms have not been updated since the inception of the program. This needs to be done by the MoHSS and IntraHealth will support this process. In the meantime, IntraHealth has updated the monthly reporting template to make provision for the new indicators.
- Although partners are able to verify data submitted to IntraHealth during the visits, there is a need for them to keep a proper organized filling system of all documentation at the sites to enable easy verification process.

Planned Events for the Next Quarter

- Continue with supervisory visits, data quality assessments and verification to all the sites.
- Ensure that all partner M&E staff receive basic training and plan to build on this with specialized advanced trainings. Staff responsible for M&E activities but not trained in the basics will be targeted in quarter one of FY2011. IntraHealth will also review data quality and verification tools and train staff, as appropriate.
- Provide guidance for collection, analyzing and reporting of data in conjunction with “Strong” campaign.
- Conduct M&E support visits to partner offices, and hold quarterly M&E partner meetings for feedback and discussion of M&E issues.
- Expand focus on evaluation of programs, including quality of care, follow up of PMTCT infants, and client satisfaction.
- Continue to support the implementation of the National M&E Association.
- Continue to support the IntraHealth prevention team, CHS and LLCL with SBCC intervention assessment
- Expand focus on reviewing program monitoring tools including for prevention.

Issues with Data Quality

IntraHealth is implementing the QI/QO (quality in, quality out) model with all partners and investing much effort to ensure that the data gathered is valid, reliable, accurate, precise, and timely. During the fourth quarter of FY2010, IntraHealth continued to institute measures to improve data quality.

The M&E team at IntraHealth continues to provide partner organizations with coaching and mentoring on data collection and data quality, improving record-keeping, program reporting standards, HMIS systems, and other quality improvement initiatives. To address the data quality challenges, IntraHealth is utilizing available tools for ensuring data quality for all program areas. IntraHealth will continue with regular data quality checks to verify that appropriate data management systems are in place and to verify the quality of reported data for key indicators at sites.

What we are doing on a routine basis to ensure that our data is high quality:

- The data clerks are supported to ensure problems with data are adequately addressed.
- At the end of each month, discrepancies between the data entered in the electronic and the paper based systems are identified and addressed at facility level.
- PMTCT register data are checked monthly by all district coordinators.
- The IntraHealth M&E Officer routinely verifies data reported monthly, and provides feedback to the reporting site.

- Data quality checks are conducted at VCT, prevention, and PMTCT and ART sites.
- PMTCT data entry into the registers is checked by district coordinators before submission.
- VCT & ART data is checked by the site manager before submission.
- HIV prevention data are checked and verified by senior management of partner organizations and IntraHealth before submission.
- The VCT & ART electronic systems have internal built-in data quality checks, which the data clerks and site managers use to check for quality and consistency.
- Data reported on a monthly basis are routinely verified and feedback is provided to the reporting sites.
- Staff that handle data are supported by the senior management to ensure that problems are adequately addressed.
- Reporting Period indicator templates submitted are checked and verified with the monthly reports submitted.
- For ART & VCT systems, data quality checks are done monthly at the national level.

Specific concerns we have with the quality of the data reported in this report:

- There is a need for continued support for partners in understanding the indicators as well as the data collection process.
- Some of Quarter 4 data reported in this report are not yet verified with the source documents.
- Although calculations in the monthly reporting templates were automated in order to minimize errors, there is a need for further improvements in data completeness, data cleaning and data quality audits for some partners.
- There is a need to further strengthen data collection for the prevention and nutritional support programs.
- The use of data by program managers at some partner organizations requires further capacity strengthening.
- Lack of M&E staff, or those responsible for M&E at partner organizations, continues to be a challenge; where existing, these staff may have competing priorities which prevent them from preparing data and reports in a timely fashion. Although many partners have M&E officers, these positions are often funded by other donors, therefore these officers are only assigned to activities of these donors. At moment, only CHS and LL/CL have M&E officers who are funded by IntraHealth.
- The problem of late reporting still exists, especially from rural sites with poor internet and courier facilities and also due to the different reporting schedule with the MoHSS.

How we plan to address those concerns and improve the quality of our data:

To be able to address all the data concerns and improve the quality of data, IntraHealth will continue to focus on the following areas:

AREA	STRENGTHS	WEAKNESSES	WHAT SHOULD BE DONE	COMPLETED TO DATE (in FY10)	FOCUS FOR FY11
M&E Capabilities, Roles and Responsibilities	• M&E Staff at IH are all skilled and hence have the minimum capacity to provide partner organizations with necessary support • There is also regular mentoring and support from USAID Namibia office. • Most partner organizations have M&E staff or staff dedicated for M&E duties. • Basic M&E training curriculum develop and available from the MoHSS	• Staff at partner organizations share M&E responsibilities for all donors for the organization • Staff at partner organizations have limited M&E skills and experience • There is no mechanisms to coordinate M&E efforts and partnerships at all levels of the system	• Encourage partners to employ M&E officers and identify staff with clearly assigned responsibilities M&E responsibilities • Continued technical support to partner organizations • Quarterly meetings with M&E staff at partner organizations and focal person • Ensure all staff at partner organizations are trained in basic M&E • Provide training on data quality and verification • Provide training and refresher trainings on the data collection tools and systems for each program • Building partner staff capacity in basic computer skills, as needed	• Partners encouraged to identify staff with clearly assigned M&E responsibilities • Continued support and mentoring provided to partner organizations • Capacity strengthening in basic M&E continues • Refresher on VCT Filemaker and ePMS system conducted	• Technical support to be provided to all levels of the partner organizations (in past was mainly focused to the site/health facility level) • Continue building capacity for partner organization staff

AREA	STRENGTHS	WEAKNESSES	WHAT SHOULD BE DONE	COMPLETED TO DATE (in FY10)	FOCUS FOR FY11
M&E plan/ Framework	• Performance Monitoring Plan (PMP) for IH has been developed and available to all partners. • Target have been developed in collaboration with partner organization and are available for each indicator per partner and per facility/site • Indictor Reference Guidelines developed by USAID and available to all partners	• Partners experience difficulty in understanding and reporting on some of the indicators. • Partner organizations didn't participate in the development of the PMP	• . Document in writing to partner organizations the program reporting requirements (what is reported to who, and how and when reporting is required) • Quarterly meetings with M&E staff at partner organizations to discuss indicators definitions and reporting requirements • Develop simple operational indicator definitions guides for partners • In collaboration with M&E persons at partner organizations, develop clear documentation on data collection, aggregation and manipulation. • During quarterly M&E meetings, identify data quality challenges and solutions for addressing them • Through partner organization, provide feedback to the reporting sites on a monthly basis in order to motivate quality of data.	• Draft reporting requirement document currently available. • Draft Simple operational indicator definition guides available	• Finalize reporting requirement document for each partner. • Finalize operational indicator definition guides • Quarterly meetings with partner organizations • Review PMP and targets with partner organizations • Conduct training on Indicators for partner organizations • Provide regular feedback to partner organisations

AREA	STRENGTHS	WEAKNESSES	WHAT SHOULD BE DONE	COMPLETED TO DATE (in FY10)	FOCUS FOR FY11
Routine Monitoring	• Data collection tools have been developed and implemented • Data clerks and Receptionist are employed at all sites/health facilities and regular training conducted for them	• Data collection is vertical especially for the non-facility based services/programs • Reporting for the health sector is centralized (from facility it flows directly to national) as there are no systems at district and regional levels • Not all systems have standardized tools eg Prevention, PMTCT • There is no documented guidelines on the verification process and reconciliation of discrepancies	• Support integration of the non-health sector system into the System for Programme Monitoring (SPM) • Support the MoHSS to developed systems at district and regional levels • Support the review of PMTCT tools and • In collaboration with the MoHSS and CDC, update monthly reporting tools and systems for PMTCT and ART programs to accommodate IH and other partner reporting requirements • Regularly update data collection tools • Harmonize data collections tools with the MoHSS and other partners to ensure that all partners use standard data-collection and reporting forms	• Draft national Care and treatment database for HIV developed • PMTCT reviewed and standardized for all sites • Draft Prevention tools developed • Draft guidelines developed for data verification and auditing • PMTCT monthly reporting tool updated and circulated to all partners; tool used for Q3 and Q4 FY2010 reporting	• Finalize national Care and treatment database for HIV • Support the MoHSS with HIV M&E systems at district and regional levels • Support the review of PMTCT and MC tools and implementation of the new tools • Print and implement the new prevention tools • Develop guidelines on the verification process and reconciliation of discrepancies • PMTCT monthly reporting tool updated and circulated to all partners; tool used for Q3 and Q4 FY2010 reporting

AREA	STRENGTHS	WEAKNESSES	WHAT SHOULD BE DONE	COMPLETED TO DATE (in FY10)	FOCUS FOR FY11
Program Databases and Links with National Reporting System	• There is a database to capture data from each program at IH national office. • IH supports databases development for the MoHSS at national, regional and facility levels • Planned networking of the systems at the facilities has been implemented and technical support exist for networking • There is available human resources with limited skills in management of databases at the facilities levels	• Databases at partner organization national offices are non-existing for most programs, therefore in most cases monthly summary data or copy of the databases are sent from the site/health facility level directly to IH national office • There is no standardized national database for all HIV programs at national level	• Support partner organization national offices to develop databases for all programs • Encourage consistent review of data by partner organization national offices • Align partner and IH data collection and reporting systems with the national Reporting System • Support the development of the national M&E system • Integrate partner reporting into the reporting process for the System for Program Monitoring (SPM) and continuing strengthening the collaboration between the partners' organizations, the Regional Councils and the National M&E office.	• Submission of data done thru the partner organization focal person at their national office • Draft national Care and treatment database for HIV developed • Continued support to the development of the national M&E system • In process of integrating partner reporting into the reporting process for the System for Program Monitoring	• Support partner organization national offices to develop databases for all programs • Continue to develop database and IT skills for partners • Continued support to for integration into the national system.

AREA	STRENGTHS	WEAKNESSES	WHAT SHOULD BE DONE	COMPLETED TO DATE (in FY10)	FOCUS FOR FY11
Supportive supervision and data auditing	• At IH national office, operational and supervision guidelines are in place for routine monitoring and supervision and mentoring guidelines were developed and are being used to mentor partner organization • IH supervision and mentoring is done directly at site level • Partner organizations national offices have developed guidelines and also do regular supervision to the sites/health facilities	• Mentorship and supervision activities are not conducted regularly as planned by IH as well as by partner organization national office	• Strengthen supervision and mentorship activities • Support partner organization national office to conduct regular supervision to sites/health facilities • Through partner organization, provide feedback to the reporting sites on a monthly basis in order to motivate quality of data.	• Mentorship and supervision work-plan developed • Mentorship and supervision visits conducted to partner organizations	• Continue strengthening supervision and mentorship activities • Build capacity for supervision and mentorship at partner organizational national office • Participate in supervision and mentorship organized by partner organizations

7. FEEDBACK ON COMPLETING THIS REPORT (OPTIONAL)

[NOTE THAT THIS SECTION IS OPTIONAL FOR Q4]

What we liked about it

What we didn't like about it

How to make it better

IntraHealth endeavors to continually improve the quality of its program in Namibia, as well as our reporting. Consequently, we kindly request formal feedback from USAID, either in writing or verbally through a meeting, on this report at your earliest convenience.

8. SUCCESS STORIES (OPTIONAL)

[You are invited – but not required – to submit success stories from the past quarter.]

**The Economist Article on HRIM
Health ministry receives new IT system to manage HR functions
Written by Johanna Absalom

Friday, 09 July 2010 09:42

In July 2010, IntraHealth handed over the computer equipment and new data centre that was acquired and implemented for the Ministry of Health and Social Services (MOHSS). The equipment was received for the MOHSS by the Honourable Dr. Richard Kamwi with the following words: "The improvement and strengthening of the HR system performance is crucial to the achievement of our National Development Plan 3 (NDP3) targets, the Millennium Development Goals and Vision 2030 goals. I therefore believe that this project is of paramount importance as it will be providing us with the necessary information to assess our human resources needs, make optimal policy decisions on human resources, plan effectively and assess the performance of our human resources." Handing over the equipment on behalf of IntraHealth, the mission director Gregory Gottlieb said, "with this system in place, Namibia will be positioned to successfully manage human resources for health challenges that it faces. The National health workforce database that HRIMS provides will supply more reliable information on workforce demographics, training needs, and workforce capacity than possible before. A weak health system is one of the greatest barriers to increasing access to basic healthcare. Governments must shape sound, efficient health systems that provide effective disease prevention and treatment to all women, men and children. In the face of a weakened global economy where the resources are becoming increasingly scarce, efficiency and effectiveness has become ever important. Accountability and effective resource allocation are the hallmarks of this type of strong system."

This event was covered by all the major local newspapers and well attended by MOHSS, USAID and IntraHealth representatives. The above is an extract of an article that appeared in The Economist of Friday, 09 July 2010.